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ABSTRACT

The majority of long-term, non-transient homeless people in Detroit, Michigan are elderly. An understanding of the elderly homeless population in terms of demographic characteristics, family relationships, economic and health status, and other factors is a prerequisite to determining appropriate courses of action for those who provide services to the aging. This document presents the final report of such research. A literature review is included which reveals that the homeless elderly represent a highly variable population according to gender, education, mental and physical health, family relationships, and other issues. Development of a 61-item questionnaire used in completed interviews with 85 homeless elderly individuals in Detroit is described. Sections on research findings focus on characteristics of Detroit's elderly homeless population; the fear and reality of criminal victimization; and the sub-minimally housed elderly. A section on "notes from the field" is followed by conclusions and recommendations and final comments. Descriptive statistics and contingency tests are presented in the tables and appended materials. References are included. (NB)

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Fall 1989

Michigan Office on Services to the Aging

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AGED, ADRIFT AND ALONE: DETROIT'S ELDERLY HOMELESS

FINAL REPORT TO THE DETROIT AREA AGENCY ON AGING
WITH FUNDS PROVIDED BY
THE MICHIGAN OFFICE OF SERVICES TO THE AGING
LANSING, MICHIGAN

OCTOBER, 1988

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INTRODUCTION

Homelessness in America is one of the most heralded issues of 1988. Perhaps because of political campaigns or because the pain and disgrace of widespread homelessness became too great to ignore, all sectors of the society have been confronted. So, also, as individuals we have been confronted by the growing presence of homeless men, women and children on the streets as we go about our daily routines. We look at them, offer charity, discuss them with our colleagues and families, and are thankful that we are not among them; yet we fail to understand why they are homeless or who they are. Most often, we look away.

During the debates and emotional public discussions about homelessness in America since 1984 the descriptions of young families who have been forced onto the street because of plant closures, job loss, disruption of social services, lack of affordable housing, and other problems has occupied most of the public's attention. Indeed, there is general agreement that young families, runaway youth, single parents and children are homeless in America in larger numbers than ever before. The numbers of such unfortunate people appear to be increasing at a startling rate. Rarely, however, has the public debate over homelessness focused on the more traditionally homeless populations in this country; the elderly men and women who live on the streets of every major city. It is unusual for the plight of the elderly homeless to capture the attention of those for whom homelessness has recently become an issue of importance. There have been no best selling books that have provided intimate portraits of men and women who have been out of work and out of luck for most of their adult lives. Older people who have been abandoned by their families rather than displaced by foreign industrial competition have not become symbols of political or economic problems.

The majority of long term, non-transient homeless people, however, in Detroit are elderly. This is also true of the residents of many boarding houses and single room occupancy (SRO) hotels that warehouse thousands of poor people at sub-minimal levels of security, sanitation or hygiene. While young people are on the streets in greater numbers, and substance abuse treatment services now have more youth who are addicted to cocaine than aged alcoholics, the traditional homeless population of older people has continued to survive on a day-to-day basis, unaffected by the attentions of those who have recently discovered homelessness.

The need to understand the elderly homeless population in terms of demographic characteristics, family relationships, economic and health status, and other factors is a prerequisite to determining what, if anything, is an appropriate course of action for those who provide services to the aging. The basic purpose of the research described in this report is to provide such a fundamental understanding of this population at risk.

This report is the final report of work conducted under contract with the Detroit Area Agency on Aging. Funds for this project were provided by the Michigan Office of Services to the Aging. Work was completed by selected faculty and students of the College of Health and Human Services, Eastern Michigan University between May and September, 1988. Field support was graciously offered by numerous service providers. The staff of the Detroit Health Care for the Homeless project, affiliated with the Department of Community Medicine of Wayne State University, screened and coded clinical data for analysis in this effort. Interviewing assistance was provided at one field site by two Family Medicine students of the Department of Family Medicine, at Wayne State University.

LITERATURE REVIEW

Investigations of homelessness have been a tradition of the social welfare, social sciences, and health sciences for most of the last 40 years. During the most recent ten years, however, the number and sophistication of applied and theoretically oriented research have increased dramatically as the issue of homelessness in America has become a priority consideration of governments, religious organizations, and the social consciousness of the general public.

The purposes of the literature review for the present study of Detroit's elderly homeless included the need to understand how the most relevant research in this field has been conducted in terms of design and selection of variables to measure and the primary research findings that are consistent, if any, for elderly samples. A comprehensive search through the social science, health science, and technical literatures yielded numerous analyses of vagrant populations, single room occupancy hotel residents, homeless people in shelters and temporary housing services, and surveys of street people. The majority of studies have emphasized one of the major conceptual areas such as the problems of alcoholism or other substance abuse, deinstitutionalization of mental hospital patients or the shortage of low income housing. A few studies have been more broadly inclusive of an array of demographic, physical and mental health, economic, social psychological and other concerns.

This review will not comprehensively analyze the large and pertinent literatures that have been examined in the course of the Detroit project. A comprehensive list of documents is provided as Appendix A. which displays the major studies that we have found to be of specific relevance to the present effort. The Appendix compares these studies according to the date of data collection, the location, sample size, primary emphasis, and sources of data. Along with other references, these studies provide a point of departure for design issues and findings of this study.

From a methodological standpoint, few studies have emphasized only the elderly homeless and those have usually included only men. These studies of elderly homeless include 1953 study of single room occupancy residents in Detroit, the work of Cohen and his co-workers in the New York's Bowery District, and Keigher's 1987 analysis of Chicago's homeless elderly client files from emergency shelter and social service records and key informant interviews under the auspices of the Chicago Department of Aging and Disability.

One recent study of homelessness in Detroit shelters (Mowbray, et al.,1986,) emphasized the conceptual area of mental health and the extent of mental illness and deinstitutionalization among the homeless. This study was a product of an ongoing concern about the role of deinstitutionalization and other factors in the etiology of homelessness within Michigan. In 1986 the Michigan Governor's Human Services Cabinet received a report from the Task Force on the Homeless, composed of representatives of major State Departments, based on secondary analyses and testimony which also emphasized the significance of homelessness in Detroit. These Michigan studies, however, did not focus on the conditions of the elderly homeless. Nor were these works designed to include a broad spectrum of issues from personal interviews from elderly homeless individuals in a variety of field settings.

Several research articles have discovered the importance of the elderly homeless as a particularly vulnerable subset of a larger problem. It is noteworthy that investigations into the broader question of homelessness have empirically found elderly people to be unique and worthy of special attention. One objective of the present effort has been to provide data with potential utility for program and policy development by the Detroit Area Agency on Aging. The broad mission of this agency, synonymous with the scope of the Older Americans Act (1973) precluded an emphasis on the singular significance of mental illness, housing adequacy, substance abuse, domestic violence or other substantive factors. Several studies of homelessness, including the most scientifically rigorous, have provided models of methodology and depth of inquiry.

The nature of the problem compelled us to consider the mutual importance of mental and physical functioning, family relations, housing, transportation, income, and personal experience. A less broadly charted scope would not provide an adequately diverse data base for service planning within the context of an Area Agency on Aging.

Among the most significant previous works that deal with the broad issues of homelessness and employ scientifically rigorous research methodology are the study of homelessness in Ohio by Roth, Bean, Lust and Saveanu (1985) and the surveys in Chicago by Rossi, Fisher and Willis (1986). The Ohio study incorporated the efforts of five coordinated teams of investigators with identical protocol, including an interview survey of homeless persons. This effort encompassed the entire state of Ohio and represents the only scientifically adequate study of a large and geographically dispersed population (twenty Ohio counties).

The Chicago study attempted to develop a methodology of identifying and measuring the size of the homeless population at a moment in time as a way to verify or refute the assertions of the magnitude of the problem in Chicago. As a result the limits of interview length and methods of screening potential respondents as sheltered or homeless were defined for adoption in the present effort in Detroit. In addition, the Chicago study's methodological development provided questionnaire items of tested value for screening and for exploring key issues of the availability of alternative housing, supportive family or friendship systems and other important questions.

A third study, this one conducted in Los Angeles by Koegel, Farr and Burnam (1986) compared samples of welfare system clients in voucher hotel rooms against skid row homeless and clarified the heterogeneity of the homeless population. Also, expanding upon the Chicago methodology, the Los Angeles team developed methods of gaining access to the sample for further and more extensive data collection.

Another series of investigations in Chicago, mentioned above, by Keigher was initiated under a Gerontological Society of America Fellowship in 1987. This study, the only one of significance with a substantial data base that focused on the elderly homeless, identified the homeless elderly as the least successful in a continuum of poor elderly who are faced with long standing poverty, loss of assets or housing due to catastrophe, and few interpersonal supportive relationships. The Keigher insights regarding the characteristics of elderly homeless people and the range of shelter from nothing to boarding houses, has significant parallels with the research findings of the present effort.

From these studies several important considerations guided the methods that were adapted for use in Detroit. The need to fully represent the geographic dispersion of the potentially homeless population, to expect heterogeneity of the homeless, and to screen persons who only appear to be homeless prior to interviewing them all became clear. Also it appeared to be likely that homeless elderly persons who are different from each other would be found, for instance, in soup kitchens, shelters, on the streets or in single room occupancy hotels. In other words it would not be adequate to seek elderly respondents only on the streets or only at meal sites or any other single type of location because all homeless elderly are not expected to use the same methods of survival.

The literature that was reviewed highlighted the need to recognize what most gerontologists have known for many years; specifically, that the passage of time increases, not decreases, the heterogeneity of aging populations. Even when homeless, the elderly represent a highly variable population according to gender, education, mental and physical health, family relationships and other substantive issues. Small samples from similar settings would not be adequate to characterize the elderly homeless in Detroit.

All serious investigations of homelessness and people who are homeless have concluded that the most consistent and overwhelming characteristic of the condition and the people is that of abject poverty. One implication of this general conclusion for the present study is that a sample of older homeless people would be expected to be at relatively greater risk during the years in which they were too old to be competitive for jobs, yet too young to benefit from entitlement programs for income or health care. This implication suggests the first guiding hypothesis of the study which is that, on the assumption that homelessness is caused, at least in part, by poverty, the elderly homeless would be more frequently between the ages of 55 and 64 than over age 65, when at least many of these elderly people would become recipients of Social Security income.

Another general observation from the literature is that homeless people present a variety of physical and emotional problems that may keep them from employment opportunities or supportive social relationships. The second guiding hypothesis for this study is that the elderly homeless are expected to present physical and emotional problems in excess of a normal aged population.

Many studies in our review of the literature emphasized the institutionalized experience of the homeless. Much has been speculated and editorialized about the outcomes of public policy on deinstitutionalized elderly mental hospital patients, for instance, that suggests that these policies at the state and national level have caused much of the homeless problem. The major recent studies in Chicago and Ohio included evidence that mental hospital, jail, prison, and substance abuse detoxification programs have been places of institutional experience for the majority of the homeless. In this study of Detroit's elderly homeless, therefore, the third guiding hypothesis is the expectation that many of the respondents have had institutional experiences in mental hospitals, the criminal justice system, detoxification programs or a combination of these prior to their homeless condition.

At a fundamental level of poverty it is difficult to overcome the inertia of poor health, depression, unkempt physical appearance, and impaired social skills in an effort to escape into an employed and self-sufficient condition. The Chicago study, as an example, found the homeless to be unable for a variety of reasons to be good candidates for employment at a sustained or adequate level. At the same time, however, the homeless will usually state that an employed condition is desirable, although available work for them rarely is adequate to provide independence and self sufficiency. The poor prospect for employment is exaccerbated by other factors, including the fact that a majority of the homeless are members of minority groups and

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as a population, are poorly educated. Our fourth guiding hypothesis is that the employment history for the elderly homeless will be characterized by insufficient steady employment for even basic human needs and that the demographic profile of the group will be consistent with population subsets that are usually at the greatest risk of unemployment -- particularly Black men, unskilled White men, and older women.

The design of the study, selection of specific variables to measure, and other technical issues were all determined in order to address these four principal hypotheses. Variables that were indirectly associated with addressing these expectations were included to provide specific information for use by service delivery planners and policy formulation. Additional variables, particularly questions regarding victimization and violence, were included subsequent to the pilot testing of the questionnaire when such issues loomed important on an empirical basis.

METHODOLOGY

The research methodology employed in this field study included the selection of an efficient means of obtaining primary data from elderly homeless people and the avail-ability of other data sets relevant to their social and health status. Objectives and approaches were modeled from similar studies in the literature. From the start, the effort was confronted with a minimal research tradition in Michigan and the ambiguous meaning of "homeless" within the social structure of Detroit and the local health and human services systems.

Primary data, eg. data collected from the elderly home-less (themselves) were sought because it was clear from a preliminary inquiry to several service providers that few, if any, routine data are ever collected about people who utilize services to the homeless. The identification "tag" as homeless is rarely used within the service systems and cumbersome methods to identify individuals who might be homeless are unique to each service provider. Deciding how to find, gain access, and collect detailed information from the elderly homeless became the most important methodological issue of the design phase of the research.

As indicated in the introduction of this report, the elderly homeless are difficult to find. When using services, such as a free meal, elderly homeless do not remain in the site for extended periods of time before or after obtaining their meal. Also, the majority of homeless elderly maintain a daily schedule of seeking out free meals, possible free cloth- ing, or other opportunities that are available in different places, on specific days of the week, and at specific times. "Making the rounds" of these opportunities, usually on foot, occupies much of the time of elderly homeless people. While some spend considerable amounts of time in parks, bus stops or other public places, these represent a minority of the group. It was decided, therefore, in recognition of the severe time limits for data collection (approximately five weeks) to seek access to the elderly homeless first within the direct services systems while services were being delivered, be these meals or other services. The principal limitation of this decision is that most of the sample would only represent those elderly homeless who actually use services designed for them.

A secondary method to access elderly homeless was used. A limited number of elderly homeless people were identified on the streets, in parks or other places and approached by members of the research team. If verified as appropriate for the study, these interviews were conducted immediately. The field team adopted the practice of keeping copies of the questionnaire and the informed consent agreement with them at all times.

DESIGN OF THE QUESTIONNAIRE

Elements of two published studies were incorporated into the questionnaire used in the present research. Studies of the homeless are uncommon, particularly with field research and personal interview approaches. The Rossi, Fisher and Willis study conducted in Chicago in 1986 provided models for both the informed consent agreement and several specific questions that were rigorously pretested. It was also considered desirable to replicate specific questions of central significance in order to provide a basis of comparison between the findings of the present data and other urban homeless populations. A second set of previously developed questions was taken from the 1984 study of a normal population of Washtenaw County elderly by Douglass and Schuster in 1984. In addition to these sources, a Hasseles Scale was developed by Hodgkins that has been used extensively with low income elderly patients at Detroit Receiving Hospital's Family Practice Clinic.

The questionnaire was designed to require approximately 30 minutes to complete with up to ten minutes devoted to establishing a working relationship between the interviewer and the respondent and for open-ended questions that call upon the interviewer to document exact text from the respondent. From previous field work and as reported by others who have interviewed the homeless a format requiring more than 30 minutes was considered to be undesirable. This was underscored by our inability to compensate the respondents in any way. The Chicago study, by contrast, was able to pay respondents for their time.

The questionnaire was pretested with homeless elderly individuals who were recruited for this purpose from the Ann Arbor Homeless Shelter. Based on the pretesting session, several questions were eliminated due to ambiguity, excessive time for response, or expected homogeneity of response. With this being the first field study of elderly homeless in Detroit, certain substantive areas were not included that, upon hindsight, would have been important. Specifically, direct questions about alcohol consumption, experiences with family violence in the past or recent past, and detailed information about mental hospitalizations would have contributed details that would facilitate our appreciation of the etiology of homelessness among Detroit's elderly. As noted in our conclusions and recommendations, these areas should be pursued in future studies now that we have established the feasibility of a primary data approach to the subject.

The final version of the questionnaire includes 61 specific questions that, when divided into analytic variables, yielded 198 individual measures for each interview. The first section of the instrument, based on the Chicago study, clarified the residential status of the respondent and, in effect, screened out the housed elderly who were not appropriate for the study. Subsequent sections included: residence expectations; employment histories and income; sources of income; sources of other support or means of survival; military, criminal justice and medical care experiences; family relationships and social ties; acceptability and availability of emergency shelter with friends or relatives; emotional status; functional (activities of daily living) abilities; sleep patterns and places of shelter during the previous week; decision-making and personal planning behavior; victimization to crime; medical problems and the extent to which specific medical problems interfere with normal functioning; demographic, marital and educational data; and personal characteristics during the interview. Open-ended questions sought detailed information about critical life experiences, employment prospects, and expected future places of residence. All interviewers were instructed to ask each respondent, at the end of the interview, "About how many others do you know that are like you but do not use this service? (or, ... do not hang out around here?). This inquiry was intended to seek an estimate of the size of the homeless elderly population represented by our sample.

PHASE I DATA COLLECTION

The first phase of data collection included the develop-ment of a comprehensive list of service providers and places where elderly homeless people can be found. Concurrently, sources of data about the health care utilization behavior and medical services to them were sought. During this phase an initial list of providers was developed for the project by Adult Wellbeing Services of Detroit. From this list, key contacts were established and other providers were identified. Provider organizations included emergency shelters, meal services, health care services, and advocacy groups. Each provider was contacted, usually visited in the field, assessed about the likelihood of homeless elderly availability at predictable times, and if it appeared likely that five or more elderly homeless would be available during a five or six hour time period on a specific day, then a field data collection date was set.

Phase I activities yielded 56 organizations and services of which 19 were ultimately data collection sites. The Detroit Health Care for the Homeless Project was identified as the only feasible source of medical care data for the elderly homeless within the time and cost limitations of the present effort. These data, reflecting outpatient services for homeless elderly persons, do not include emergency medical care or inpatient services. Outpatient services, however, are principally delivered on a "walk in" basis and provide a profile of ongoing medical care needs for the population. A separate study would be highly desirable regarding the patient profiles of homeless people who are elderly and are admitted to a hospital. The presenting problems, diagnoses, treatments and discharge dispositions of these patients are poorly understood and may present important insights for service delivery planning and public policy.

It is worthy of mention that the research effort was virtually always welcomed by service providers and frequently the staff was offered assistance well beyond the scope of our requests. Some providers assisted in the identification of homeless clients to be interviewed, others assigned staff members to the task of assisting the research team. Providers frequently suggested places where elderly homeless can be found and insights into the daily patterns of homeless people. There was no hesitation among some providers to candidly indicate that homeless elderly people do not use their service. Their assistance was invaluable as we sought to identify places to find elderly homeless within a short period of time.

PHASE II DATA COLLECTION

Prescheduled data collection days usually included blocks of time at two or more locations with three to seven inter- viewers involved with screening and interviewing respondents at each location. The nature of the problem of homelessness, however, virtually defined this plan as a necessary but inefficient field process. More efficient approaches were not in evidence. On several occasions a field team of six or more were able to identify and interview fewer than five homeless elderly persons in a full day. At other times the team was too few to take advantage of all the elderly homeless who were available within a two or three hour period of time. When periods of service were concluded, such as when a meal service was no longer open, the elderly homeless would retreat into unknown places and further interviewing was impossible.

Most interview data were collected between 8:30 A.M. and 6:30 P.M. Twelve interviews were collected between 8:00 P.M. and 1:00 A.M. All interviews were collected between June 29 and August 10, 1988. It is relevant that this period of time was exceptionally hot and dry and several service providers informed the research team that more typical and rainy weather at night would increase the utilization of services and the availability of potential respondents. Two scheduled field days were cancelled because of the severity of weather and the potential personal risk to interviewers. During the period of field work one of the data collection sites was the scene of a homicide during the day and several sites experienced fights, assaults and other violence. Personal risk to the research team was an important consideration during the scheduling and conduct of all field work.

During Phase I interviews it was determined that shelters, meal sites, single room occupancy hotels, and rescue missions do not serve identical populations. It was decided that all of these types of service sites would need to be included in the data collection, plus other sites, in order to fully represent the expected range of elderly homeless people. In other words, reliance on shelters, or meal sites, or street level interviews would produce an expected bias in the characteristics of the respondents. Such a bias was discussed above in the review of literature and previous research. We considered it important to identify and interview the broadest possible range of homeless elderly people.

A total of 119 interviews were conducted in the field. Of these, 85 were determined to be complete, appropriate and suitable for statistical analysis. Two interviews were unusable because of the uncodable, confused content of the answers. To an extent these interviews verified that mental illness does characterize at least some elderly homeless. Other interviews were too incomplete to include; usually the result of a respondent walking away from the interview or falling asleep. One interview was too incomplete to include because, after eight questions were answered, the interviewer was told that the respondent had to "make a sale", presumably of illicit drugs, and the interview was terminated.

From the onset, a concern of the research team was how to develop a sample of elderly homeless that was represent-ative of an otherwise undocumented population. Although it is clearly a sample that has proximity to services and few of the respondents of this study use no services at all, it is also true that in the latter weeks of data collection the team recognized people who had been interviewed before at different locations. These "repeaters" constituted almost half of the elderly homeless at one field site on the final day of data collection. While it is not possible to know the actual representativeness of this sample in relation to the total population of elderly homeless in Detroit, it is possible to have confidence that the sample fairly represents those elderly individuals who use the principle service sites for shelter, food, clothing, and health care for the homeless.

The staff of the Detroit Health Care for the Homeless project were invaluable to the research by screening clinical records of patients 55 and older and coding the selected 220 records by nine independent variables: gender, race, age, frequency of clinical visits, number of prescriptions, number of hospitalizations, referrals to other health care services, principal complaints, and principal and secondary diagnoses.

ANALYSIS DESIGN

The analyses incorporated in this initial examination of the datasets built during the project include a full descrip-tive statistical presentation of all quantified variables, cross tabulations of all variables by gender, age, race and estimated income, and selected stratified cross tabulations in substantive areas of interest to the principal investigators. These include functional abilities, victimization to crime (especially violent crimes), and family relationships. The rich datasets derived from the field work will be continuously analyzed during the months between October, 1988 and June, 1989 for purposes of scheduled symposia, publications, invited lectures and other purposes. The products of these efforts, including additional interpretation and more elaborate statistical procedures, will be routinely forwarded to the Detroit Area Agency on Aging and should be considered to be appendices or additional chapters of this report.

For purposes of convention, descriptive statistics and contingency tests will be presented in the tables and appendix materials provided in the following sections of this report. A standard acceptable level for statistical significance of $P < .05$ used for all analyses.

In addition, the principal investigators have offered directors of service programs that were instrumental in the design and execution of the field work the opportunity to access the data files from this study for purposes of service planning or proposal development for a period of one year. This "on call" data analysis capability is one way that the project team can repay the people who made the research possible.

CHARACTERISTICS OF DETROIT'S ELDERLY HOMELESS

All recent studies have concluded that the conditions of homeless people are wretched. The characteristics of Detroit's elderly homeless present a profile that should profoundly disturb all citizens of Michigan. We feel that the gnawing poverty, despair, vulnerability and hopelessness of this population should not be overlooked amidst a flurry of specific measured characteristics. Our most significant single impression is that these citizens of the State of Michigan live, in the City of Detroit, as no one anywhere should have to live. Long after this report has faded from memory, we will clearly remember the faces, the words, and the tragic humanity of our respondents.

These impressions, however, cannot be transferred objectively without a systematic examination of several areas that were investigated in our interviews. These areas will be discussed below and include: demographic and socio-economic characteristics; the duration of homelessness and sources of immediate shelter; employment and income measures; institutionalized experiences; social relationships; health status and health care utilization; criminal victimization; and our hypotheses of pathways into and out of homelessness.

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

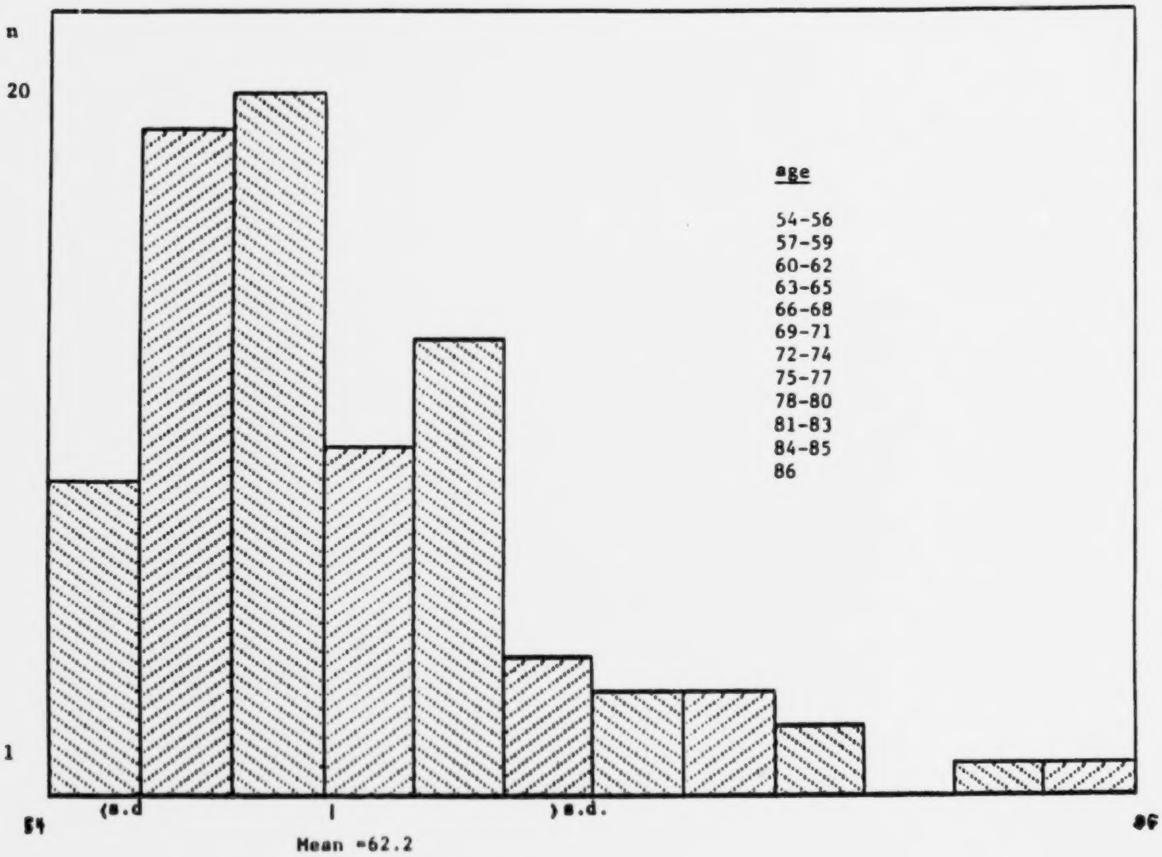
The 85 complete interviews with homeless elderly individuals included 17 women and 68 men. Of the women, nine were white and eight were black. Twenty-five of the men were white, 40 were black and three were hispanic. This represents a slight over-representation of black individuals in that less than 50% of the Detroit population over age 60 is black, versus 55.3% of this sample.

The age distribution is displayed in Figure 1 and indicates that somewhat more than half of the sample is below age 65, with an average age of 62.2 years and a range from 54 to 86. The implications of this age distribution will reveal themselves throughout the presentations of our research findings and will be particularly clear in the discussion of income. It is significant that the homeless elderly population is largely composed of the "young old" rather than the "old old" an it is possible to speculate that increasing age is associated with mortality, development of medical problems that lead to a Medicaid nursing home placement, or obtaining economic entitlements, particularly Social Security payments, that provide a means of obtaining shelter.

The income of this sample for the month preceding the interview was a metaphor for all other findings about these people. Among the respondents, 35 or 42.7% stated that they

FIG 1. RESPONDENT AGE DISTRIBUTION

Cases = 85   Max Freq = 20



had less than $200 for all of their needs during the preceding month. As displayed in Figure 2., a minority of the sample claimed as much as $400. In all, 78% of the respondents claimed under $400 total income for the month prior to the interview.

When analyzed according to age and other demographic variables, 18% of respondents aged 64 or younger reported earnings of $400 or more while 25% of those aged 65 or older reported incomes in the higher ranges. The women in this sample reported higher average incomes than the men, with 35% indicating that their last monthly income was at least $400 and only 18% of the men reported that their income was this high. In terms of total reported income, race does not appear to be a dominant variable. Over 75% of both black and white homeless in this sample reported incomes under $400 per month. Two of the three hispanic respondents reported this income. Further analysis, however, reveals that 52% of the white respondents reported under $200 in the preceding month and 34% of the black respondents reported this lowest income level. This is one of several instances that, for the homeless elderly, conventional social indicators do not seem to apply, in that in a cross sectional sample of the resident elderly of an urban area the elderly white respondents would be less likely than the elderly black respondents to report the lowest income levels. We would like to caution against inappropriate interpretation of these income data, in that the maximum reported income was slightly over $600 and that applied to only seven individuals (8.5%). All respondents were, by any standard, very impoverished. Our income data are meaningful when viewed in relation to comparisons of subgroups within the homeless sample.

The elderly homeless of Detroit, like homeless people in other age groups and in other places, are largely unattached individuals. As displayed in Figure 3, the largest group of the sample are either divorced, separated or single and never married. These two categories apply to 68.6% of the sample. Nineteen percent of the sample were widowed and 7%, all men, claimed that they were married, although there was no evidence that their spouse was around during the interview. Four men reported that they had been abandoned by their wives. The largest group of men were separated or divorced (41%) followed by men who had never been married (29%). Thirty five percent of the women were widowed, and 24% reported being separated or divorced. Thirty five percent of the women also reported being single and never married. One woman did not report marital status. When considered according to race, as presented in Table 1., different patterns appear between white and black respondents. While comparable proportions of the white and black samples reported being married, divorced, separated or abandoned, very different proportions reported being widowed or single and never married. Black respondents

FIG 2. RESPONDENT INCOME - MONTH PRIOR TO INTERVIEW

Cases = 82 Max Freq = 35

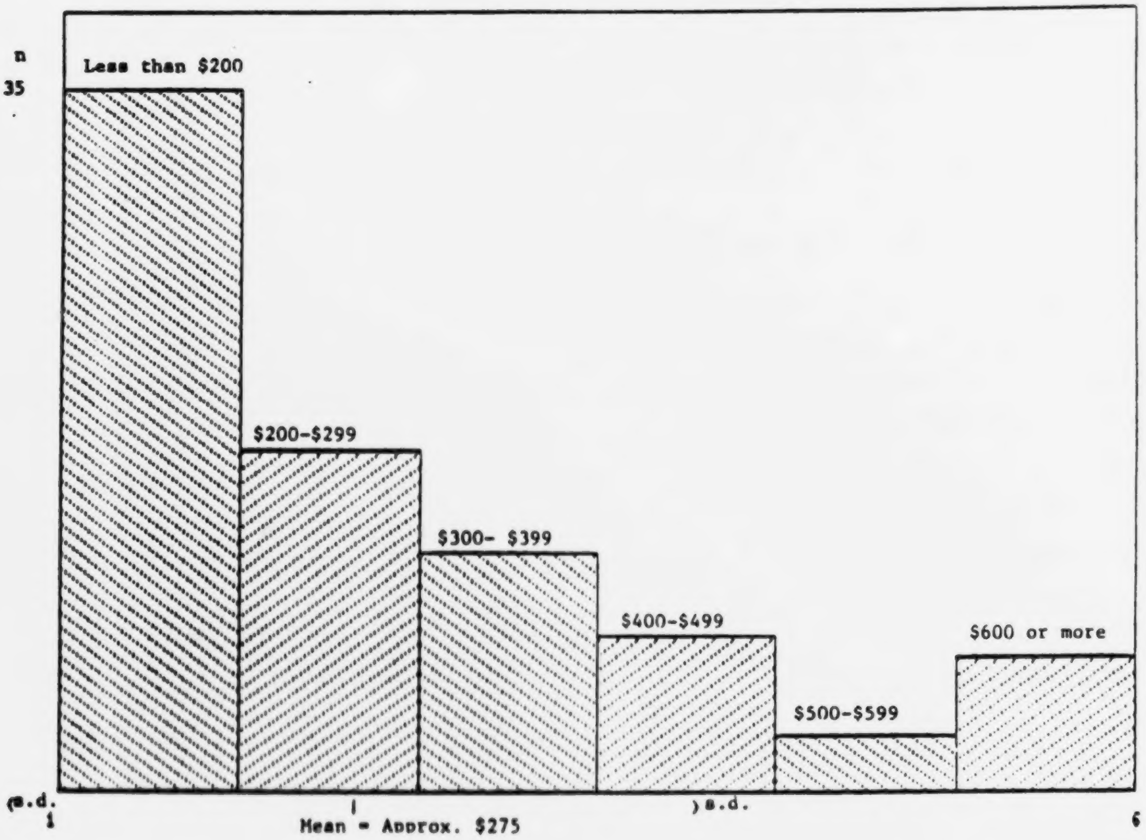
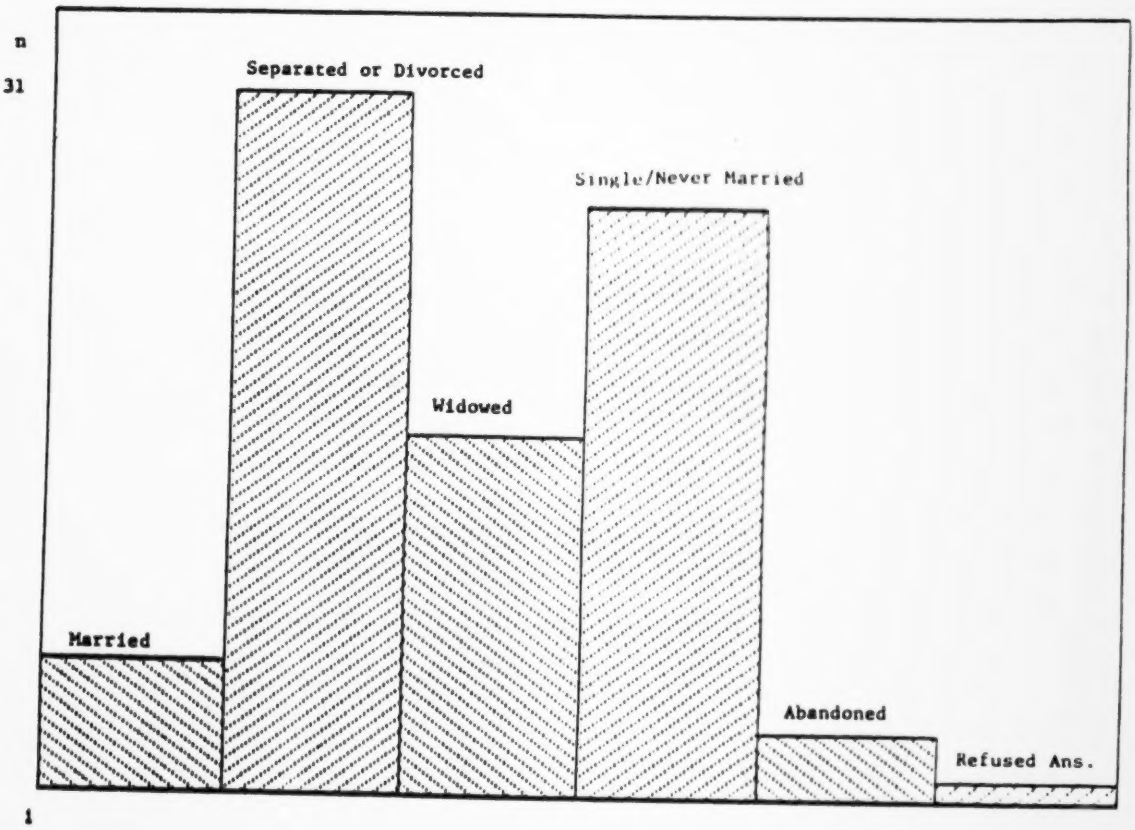


FIG. 3 RESPONDENT MARITAL STATUS

Cases = 83 Max Freq = 31



were over three times as likely to be widowed as were white respondents while white respondents were twice as likely as their black counterparts to be single and never married.

TABLE 1. MARITAL STATUS BY RACE

	White	**Black**	**Hispanic**
	n %	**n %**	**n %**
Married	1 (3%)	3 (6%)	1 (33%)
Divorced or Separated	13 (39%)	17 (36%)	1 (33%)
Widowed	3 (9%)	13 (28%)	
Single	14 (42%)	10 (21%)	1 (33%)
Abandoned	1 (3%)		

As an indicator of income, moreover, those respondents with the lowest income, under $200 in the preceding month, were most likely to be separated or divorced (45.2%), single and never married (46.2%), or abandoned by their spouse (75%). Five of the seven individuals who reported incomes over $600 were separated or divorced and two were widowed. Sixty eight percent of the widowed individuals reported incomes of over $400 in the previous month.

It is reasonable to anticipate that this sample of elderly homeless has not experienced high levels of achievement in education. As displayed in Figure 4. the levels of education achieved are low, even when considered against normal populations of the same age. Over 58% of the sample did not complete high school and only 21.4% earned a high school diploma. A somewhat surprising 20.3%, however, did complete some post secondary education and three respondents were college graduates. Of those with the least education 11 out of 13 were black. More than half of the total sample did not complete high school (56% white, 59% black, 66% hispanic). An equal proportion of both black and white samples earned high school diplomas (21%), however, 26% of the white sample compared to only 16% of the black sample had any post secondary education. Sixty-two percent of the

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men in this sample failed to complete high school, while only 41% of the women were not at least high school graduates.

Educational achievement, however, was not meaningfully related to income with the largest subgroup of respondents at all levels of education falling into the lowest reported preceding monthly income level as shown in Table 2. We consider the differences between those with at least a high school education and those with less than that level to be, at best, a statistically significant but academic distinction.

TABLE 2. PRECEDING MONTHLY INCOME LESS THAN $200 ACCORDING TO LEVEL OF EDUCATIONAL ACHIEVEMENT

Educational Level	Previous Monthly Income Under $200
Did Not Finish Elementary School	42.9%
Grade 8 to 11	48.6%
High School or Equivalent	33.3%
Some Post-Secondary	38.5%
College Degree	33.3%

A less traditional and, perhaps more meaningful, characterization of the elderly homeless respondents in this sample is drawn not from typical income, demographic or educational variables, but from descriptive terms used by the interviewers that were coded for all respondents. These included indica-tions that only 12.9% were afraid to be interviewed, 41.2% were neatly dressed, 56% were lucid and articulate, only 17.6% appeared to be carrying their possessions in bags or packages, 44.7% were very poorly dressed, 29% were visibly dirty and appeared to have been so for several days or more, and 25.9% were confused during most or at several points in the interview. Along the same vein, we consider it highly significant that in response to the question, "In the last month was there any time when you didn't get anything, or barely anything to eat for 2 days or more?", 42.4% said "Yes" including 2 of the 3 hispanic, 20 of the black and 13 of the white respondents.

THE DURATION OF HOMELESSNESS AND PLACES OF IMMEDIATE SHELTER

All except three of the respondents in this study claimed to be residents of Detroit and 84.7% claimed to have lived in the city for more than five years. Only eight respondents suggested that they would stay in Detroit for six months or less while 72.3% indicated that they planned to stay for more than a year. The sample were predominantly permanent Detroit residents who had lived all or most of their lives within the city limits. While 52.9% of the respondents claimed to have "a regular place that you [they] consider[ed] to be your home", it is significant that none of the respondents in this analysis planned to sleep in that place on the night of the interview. In fact, anyone who answered affirmatively to these questions was screened out of the study as being probably housed.

Among the respondents in the analysis, 22.6% planned to sleep in a hotel room, 23.8% were staying in a shelter for the homeless or a rescue mission, 23.9% were to sleep in a friend or relative's home, and 29.8% either did not know where they would sleep or that place included a park, public place, abandoned building or car, or under a bridge. The variety of responses to this question may have been somewhat affected by the date of data collection, July, 1988, and the hot and dry weather conditions that had prevailed for several weeks. It may be expected that in less favorable weather conditions more respondents would have had specific plans regarding where they would find shelter for the night.

Among the 39 individuals that claimed to have a regular place to call home, 13.4% had been there within one week and 12.8% had not been there in one year or longer. Individuals who did not have a place that they considered to be their home were likely to have been without a home for more than a month (57.3%) and most of these (40.2%) had been homeless for a year or longer. Forty-three percent of the respondents stated that they expected to have a place to live in the near future, although few of these responses were matched by a specific address or building. Fifty-four percent of the respondents either stated that they did not have such plans or that they didn't know if their future included a place to live.

The prevailing condition among these people was a long period of homelessness and an uncertain likelihood of known housing in the future. In addition, more than half of the respondents indicated that their last regular home was one in which they lived alone, rather than with someone else and of these individuals, 58.5% had not lived with anyone else for five or more years. Approximately one third of the total sample had been homeless in each of the last four years, including 1984 - 1987. Twenty-five percent of the sample had been homeless for much longer periods, ranging from five to twenty years.

The respondents who had last lived with someone else were most likely (31.1%) to have lived with a spouse. Other relatives (20.5%), friends (17.6%), and unrelated adults (9.5%) were the next most likely sources of housing for these respondents in contrast to only 8.1% who had lived with their children. Of those who had lived with their children or other relatives, 8 women indicated that they became homeless only after their supporting family members had exploited their assets, stolen their home and forced them to leave. This group of women represents over half of the women in the sample. The respondents in this study, in general, have had little regular contact with a nuclear family situation in recent years. Only three individuals had ever lived with a spouse and their own children. Seven individuals had not lived with anyone else since they left their original nuclear family as youth.

EMPLOYMENT AND INCOME

The general income status of the sample has been described above. The relationships of income to employment, however, require further discussion. Fifty-two (62.7%) of the respondents indicated that they were interested in working for pay or getting a regular job. An additional five respondents indicated that they would if the job was one that they could accomplish with their physical disabilities or limitations. Only eleven (12.9%) of the respondents had actually had a job that provided income within one month of the interview and only six of these individuals stated that the job was sufficient for their income needs. From their status as homeless and either in a shelter, food service, or other location, it is reasonable to suspect that fundamental needs were not adequately provided with the employment available to these six individuals.

Sources of income for the sampled elderly homeless are presented in Table 3. This table clearly demonstrates that the elderly homeless are poorly served by formal systems of income support and interpersonal sources are virtually irrelevant. The single most frequently stated income producing activity among the sample was collecting bottles and cans for a refund. The welfare system, Social Security, and Supplemental Security Income assisted less than half the sample. Friends and relatives had provided money to only six individuals out of 85 in the sample during the month preceding the interview.

TABLE 3. SOURCES OF INCOME

	n	%
Welfare, Department of Social Services, General Assistance	30	35.7
Social Security	30	35.7
A Retirement Pension	7	8.5
Relatives or Family	3	3.6
Friends	6	7.2
Unemployment Insurance	1	1.2
SSI (Supplemental Security Income, not including old age pension)	16	19.0
Disability Payments	6	7.2
Veterans Administration Benefits	7	8.3
Selling Personal Belongings	8	9.5
Gifts	5	6.0
Handouts from Strangers	15	17.9
Collecting Bottles and Cans	37	44.0
Other	10	12.1

In addition to the sources of money that are listed above in Table 3, 31.3% of the respondents benefitted from Medicaid for medical services, 24.1% were able to obtain Food Stamps, 39.3% obtained free clothing, 83% found free meals and 45.2% took advantage of a free place to sleep, other than a public place such as a park or abandoned building. Almost half the sample (46.6%) were certain that they did not take advantage of services that might be available to them, and 26% of the sample did not know if they were using all available services.

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INSTITUTIONAL EXPERIENCES

Many studies of the homeless in America have determined that most homeless individuals have had significant experience with mental health, criminal justice, or detoxification institutionalizations. The elderly homeless of Detroit are not exceptions to this general finding. In order to pursue this issue a set of questions was taken from the Chicago study by Rossi and his associates and is summarized in Table 4. The observation that approximately one third of the sample (32.5%) had ever been admitted to a mental hospital was explored further with a second specific question that asked if the respondent had ever been a patient in a mental hospital in Michigan or some other state and 26.2% of the sample said that this was true for them. Experience as a hospital patient was included to reduce the level of anxiety to the respondents.

TABLE 4. INSTITUTIONAL EXPERIENCES

	n	%
Served in the Military	35	41.2
Alcohol or Drug Detoxification	25	30.5
Admitted to a Mental Hospital	27	32.5 (26.2) *
Served Time in State or Federal Prison	19	22.6
Served Time in a City or County Jail	39	46.4
Been Placed on Probation by a Court	31	37.3
Been a Patient in a Hospital	65	77.4

* The second % refers to a validity check question which occurred later in the interview.

There were significant differences according to race in the above types of institutionalizations as seen in Table 5.

In general, white respondents were more likely than black respondents to have had institutionalized experiences in military service or mental hospitals and black respondents were more often involved in detoxification or criminal justice sanctions. No differences were found regarding hospitalizations between white and black respondents.

TABLE 5. INSTITUTIONAL EXPERIENCES BY RACE

	White		Black	
	n	%	n	%
Served in the Military	16	48	16	34
Alcohol or Drug Detoxification	7	21	16	34
Mental Hospital Admission	17	52	9	19
State or Federal Prison Time	4	12	14	30
City or County Jail Time	11	33	26	55
Probation, by a Court	10	30	19	40
Hospital Admission	25	76	36	77

The women in the sample had relatively few of these institutionalized experiences except in three areas. Twenty-four percent of the women had been a city or county jail. Fifty-three percent had been admitted to a mental hospital, and 71% had been a hospital patient. It would appear that the stereotype of the "bag lady" and other images of homelessness among the elderly is based on assumptions regarding white homeless elderly people. The majority of black homeless elderly have more likely had institutionalized experiences with the criminal justice systems. The criminal justice system is more likely to have sanctioned both black and white elderly homeless than the alcohol or drug detoxification systems.

SOCIAL RELATIONS

One important aspect of being homeless is the pattern of social relationships maintained by the individual. This would be particularly true of the present sample who are by definition in an economically deprived state, relative to individuals with homes. Earlier studies in Chicago and Los Angeles have reported that the homeless in those communities do not have extensive ties with either family or friends. This pattern of limited ties to family and friends has, at this point in the analysis, been found to be a consistent characteristic of the homeless in other communities as well. Whether such a pattern is a "causal" factor in the etiology of homelessness or simply a product of being transient is not clear from previous research.

To examine social relationships among the elderly homeless in our sample, responses that focused on contacts with family and friends were analyzed. The questions asked whether the respondents had living relatives, had they been in contact with them within the preceding three months, and did they live in Detroit or in the Metropolitan area?

This type of question, adapted from the Chicago Study, is useful in establishing in a limited fashion the existence of social ties. Unfortunately, it provides little insight into the depth or intensity of the social relationship that is being described. While intuitively it seems doubtful that social relations of such a tentative nature could provide support to the homeless, the fact that they are seen to exist at all by the respondents may be psychologically important to them. This is a question in need of further research.

Unlike family relations, which are ascribed, friendship relations are much more difficult too determine in that the definition of friendship is so idiosyncratic in nature. One person's "friend" may simply be an acquaintance to another person. To circumscribe this problem to an extent, the phrase "friends you can count on" was used in asking about current contacts and whether or not the friend lived in the Detroit area.

The results of the analysis of these questions are presented in Table 6., below.

TABLE 6. COMPARATIVE SOCIAL RELATIONSHIPS BY GENDER *

Relationship	Male	Female	Total
Living Parents	20%	7%	17%
Recent Contact with Parents (if living)	60%	100%	59%
In Detroit area (if living)	18%	75%	30%
Living Siblings	75%	50%	71%
Recent Contact	29%	50%	41%
In Detroit Area	25%	62%	36%
Other Living Relatives	65%	58%	63%
Recent Contact	29%	50%	31%
In Detroit Area	36%	44%	37%
Living Adult Children	53%	29%	48%
Recent Contact	45%	60%	49%
In Detroit Area	31%	60%	36%
Friends Who Can Be Counted On	59%	69%	61%
Recent Contact	95%	82%	90%
In Detroit Area	90%	82%	90%

* Only "yes" affirmative responses reported as percentages.

Among the elderly homeless in Detroit, only 17% reported that one or both parents are still alive. But of this group, 72% reported being in contact with their parents at least once every three months. It does not appear to be important whether or not these parents live in the Detroit area, however, as far as the likelihood of recent contact is concerned. In contrast to the small number of subjects with living parents, 71% of the elderly homeless sample reported living brothers or sisters, of whom 35% lived in the Detroit area. Only 40% of this group have had recent contact, however, suggesting that siblings are not an important source of support for the elderly homeless. We acknowledge that siblings may have been a source of support at one time, however, we have no measurements of this possibility. Adult children (natural or adopted) are reported by approximately half (48%) of the respondents. And of this group, 48% reported contacts with their siblings at least once in the previous three months.

In contrast to familial relations, a majority (61%) of the respondents reported having one or more friends that they could count on. And of that 61% the vast majority (90%) reported being in regular contact with their friends at least once a month. This difference in patterns of contact for the elderly homeless in Detroit suggests that friendship is a much more important aspect of social support--to the extent that such support can be provided--than family ties.

Some insight into the nature of this relationship can be gained by examining elderly homeless attitudes toward their families in the area of shared living. Table 7. displays the results of an analysis of respondents (those with relatives in the Detroit area) who were asked if they were opposed or in favor of living with those relatives. It is apparent that only a minority (30%) would consider living with their relatives under "the most favorable circumstances". When asked if they thought their relatives would be receptive to having them move into the relative's home, 41% felt that the relatives would be opposed, as shown in Table 8.* These figures suggest that only a minority of the elderly homeless see living with relatives as a solution to their lack of adequate shelter, even if their relatives would approve of their moving in.

TABLE 7. WOULD RESPONDENTS LIVE WITH DETROIT AREA RELATIVES IF OFFERED?

	Opposed	In Favor	Don't Know	Total
Male	60%	32%	8%	100%
Female	33%	33%	33%	100%
Total	56%	31%	13%	100%

Note: Asked only of respondents with Detroit area relatives.

The specific questions, numbers 33 and 34 in the questionnaire, asked:

33. "You mentioned that you have (parents/brothers or sisters/other relatives) here in the Detroit area. Assuming that they would want to and have the room, would you be opposed to or in favor of going to live with them?"

34. "As far as you know, would your (parents/brothers or sisters/other relatives) her in the Detroit area be opposed to or in favor of your moving in with them?"

TABLE 8. WOULD DETROIT AREA RELATIVES BE IN FAVOR OF RESPONDENTS MOVING IN WITH THEM, AS PERCEIVED BY RESPONDENTS?

	Opposed	In Favor	Don't Know	Total
Male	38%	46%	16%	100%
Female	50%	33%	12%	100%
Total	42%	42%	16%	100%

Note: Asked only of respondents with Detroit area relatives.

As seen in the tables relatively large percentages of the elderly homeless have living siblings, relatives or adult children, although relatively small percentages of each group are living in the Detroit area. Further, only a small percentage of these relatives have been contacted within the last three months. Generally these data, like data from homeless studied in other communities, suggest that the elderly Detroit homeless have very limited contact with their families.

To the extent that differences in family relations between the male and female elderly homeless exist, it is apparent that females are much more likely to maintain their family ties than are males. It should be noted, however, that the small total number of females in this study (17) tend to inflate percentages appearing in these tables.

In sharp contrast to the limited family ties of the homeless noted above, friendship relationships revealed in Table 6. appear to be active and local to the Detroit area. While the percentage of homeless reporting friends is not particularly high for either males or females, recent contact is almost uniformly high in both groups. This suggests that, unlike relationships reported with living relatives, friendship which is local and immediately available may be the most important source of social support for these respondents.

In summary, regarding social relationships, as in other studies of the homeless in metropolitan centers, the Detroit elderly homeless provide evidence of limited social relationships. This is particularly true in respect to living relatives, whether local or beyond the metropolitan area. Friendship ties, in contrast to family relationships, seem much more vital and important to these homeless, elderly people. This finding is understandable, given the circumstances of homelessness. It is not unfair to assume that some absence of family solidarity in the first instance may well have contributed to the homeless person's fall into his or her present circumstance. Subsequent experience on the street would likely do little to resolve those problem. While friendship relationships appear to be more immediately important to these respondents, it is not possible to determine how these relationships are meaningful. Are friendships important for self esteem or identity or for more practical reasons such as protection from crime, information regarding food or shelter, or simply an alternative to isolation? The qualitative meaning of friendships and the patterns of familial breakdown for the elderly homeless may be important if we are ever to understand the causes of homelessness and how individual homeless people are able to survive. Adequate information on these subjects awaits future study.

HEALTH STATUS

The health status of the homeless elderly is an area of concern for several reasons. To the extent that poor health can, in some instances, lead to impoverishment and homelessness, it points to the need for re-evaluating existing health care arrangements. Further, the wretched physical conditions of the homeless environment can, itself, be conducive to poor health, leading to an increased burden on public health facilities. And, finally, the ability of these same public health facilities to anticipate and provide for health services for the homeless is dependent upon their understanding the health needs of this special population.

To adequately evaluate the health status of the homeless elderly in Detroit would require physical and laboratory examinations and is beyond the scope of this study. Our ability to discuss the area is, thus, limited to the self reported answers to questions asked of respondents in the field. At the same time, previous studies have shown such self-reports to be reasonably valid measures of health care utilization and need. In this study we have adapted our health status questions from similar instruments used in the 1986 Chicago study and from the 1984 survey of Washtenaw County elderly, as discussed in the methodology section of this report. The focus of these questions is upon the general health status of the subjects, their past medical history, and their current needs.

Table 9. presents the findings of self reported, general health status. It is evident from this table that better than half (55%) of the elderly homeless report their health status as "fair" or "poor". This figure, influenced by the age of this population in part, is a much higher proportion of the population than that reported in either the Chicago study (36%) or a national sample (18%) in response to the same question (citation here). We can only assume that both age and hardship contribute to this difference.

When gender differences are considered, it is apparent that men in this population are only slightly more likely to evaluate their health as fair or poor than are women (56%) versus 50%).

TABLE 9. SELF-REPORTED GENERAL HEALTH STATUS OF HOMELESS ELDERLY, BY GENDER

	Excellent	Good	Fair	Poor	Total
Male	8%	36%	36%	20%	100%
Female	--	50%	25%	25%	100%
Total Sample	6%	38%	34%	21%	100%

Further insight into these figures can be gained by examining the homeless subjects' responses to questions designed to probe their prior experience with health care. Table 10. presents their responses to questions dealing with prior institutional health care services within the last year.

TABLE 10. PRIOR HEALTH CARE SERVICES OR HOSPITALIZATION WITHIN THE LAST YEAR, BY GENDER

A. RECEIVED MEDICAID ASSISTANCE (WITHIN THE LAST 30 DAYS)

	YES	NO	TOTAL
Male	29%	71%	100%
Female	43%	57%	100%
Total Sample	31%	69%	100%

B. PATIENT IN HOSPITAL, NURSING HOME OR MEDICAL CLINIC

	YES	NO	TOTAL
Male	53%	47%	100%
Female	37%	63%	100%
Total Sample	48%	52%	100%

C. TIME SINCE LAST SEEN BY A PHYSICIAN OR A NURSE IN A HEALTH CARE SETTING

	Within 3 mo	3-6 Months	6 months - 1 year	More than 1 yr	Total
Male	47%	18%	8%	27%	100%
Female	57%	7%	7%	28%	100%
Total Sample	49%	15%	8%	28%	100%

D. WAS RESPONDENT UNABLE TO RECEIVE HEALTH CARE WHEN NEEDED?

	YES	NO	TOTAL
Male	30%	70%	100%
Female	43%	57%	100%
Total Sample	32%	68%	100%

As can be seen from Panel A. of Table 10, 31% of the homeless elderly report receiving Medicaid assistance within the past 30 days. This is particularly true for women, suggesting that the earlier self-reported health status figures may be accurate. Panel B. of Table 10 lends further credence to this conclusion in that almost half (48%) of the sample received some form of institutional health care within the past year. Further support is evident in Panel C. where 64% of the homeless respondents reported that they had seen a physician or nurse within the past six months.

When gender differences are considered, in Table 10, it is apparent that homeless elderly women are much more likely to use the health care system than men, except for hospitalization. Such a pattern of sex differences in health care use is consistent with national data from normal populations. Generally speaking, men do not seek medical assistance until their health problems are severe and their need for hospitalization is increased.

A significant unanswered question in dealing with the health care needs of this sample is the actual availability of medical care to them. Panel D. of Table 10 provides some insight into the answer to this question. Approximately one third (32%) of the respondents reported being unable to receive medical assistance when they believed it was needed. This was particularly true for the women in the sample (43%). Unfortunately, transportation availability, lack of funds and simple ignorance of possibilities for health care all interact with unknown factors and make this information difficult to interpret. An understanding of barriers to utilization of health care services for this special population, as with many other groups, requires additional detailed investigation.

An important aspect of the elderly homeless' health status pertains to the presence of chronic conditions which may impede their ability to adjust to what is essentially a harsh environment. Particularly among the elderly, chronic conditions are an expected concomitant, with various levels of impairment that range from slight to severe. Table 11 rank orders the ten most commonly reported chronic health problems reported by the Detroit sample.

Dental problems are not chronic for the majority of the population. These problems tend to be acute and the basis for a relatively short term of dental treatment or functional correction. For this population, however, dental problems must assume characteristics of chronic and disabling disease in that dental care is rarely available in the short term for uninsured and indigent people. A sizable majority (65%) of the total sample had unmet dental care needs. From field observation we recalled situations in which respondents had only a few remaining teeth, severe gum disease, broken teeth, and reported inability to chew solid foods. We also suspect high levels of other oral health problems, including cancers of the lips and oral cavity, from observation. Such a large proportion of the sample, plus the scale of apparent health care need, ranks dental health care as a clear priority for future research and program development.

Arthritis and hypertension are the next most frequently reported chronic health care problems. It is interesting to note than, excluding dental problems, these two chronic conditions are also ranked first and second nationally (citation here). Circulation problems and emphysema/chronic bronchitis are common among the elderly homeless (35% and 33%), and is to be expected when the life style and living circumstances of these respondents are considered. Surprisingly, however, heart conditions, while fairly common at 25%, are not as frequent as might be expected, given the respondents' ages. We suspect that more serious heart disease ha, by institutionalization or mortality, removed heart patients from the homeless population.

TABLE 11. TEN MOST FREQUENTLY REPORTED CHRONIC HEALTH PROBLEMS BY RANK ORDER AND GENDER

Reported Problem	Male	Female	(Rank) Total
Unmet Dental Problems	68%	56%	65%
Arthritis (general)	48%	63%	53%
Hypertension	44%	45%	44%
Circulatory Problems	40%	25%	35%
Emphysema or Chronic Bronchitis	35%	13%	33%
Heart Trouble	24%	31%	25%
Ulcers/Stomach Ailments	22%	20%	21%
Glaucoma	14%	31%	16%
Asthma	12%	13%	13%
Anemia	8%	18%	8%
Diabetes	6%	13%	7%

Several gender-based differences are significant among this sample of homeless elderly. Arthritis, heart trouble, glaucoma, diabetes and anemia appear to be much more common among females than among males. Conversely, dental problems, circulatory problems and emphysema/chronic bronchitits are more common among the men.

The occurrence of previously encountered acute medical problems was also reported in our interviews. These conditions include pneumonia (32%), urinary tract infections (13%), stroke (13%), tuberculosis (12%), kidney disease (9%) and liver disease (7%). Whether or not these health conditions occurred while the subjects were homeless or before that time is impossible to judge from these data. Also, the distinction, in a self-report format, between liver disease and hepatitits, for instance, is not to be considered highly reliable for these respondents. From our observations in the field, in contrast to these lists of medical problems, the homeless sample appeared to be "tough" and not seriously troubled by their reported medical or health problems. Even those who might be expected to be seriously impaired by virtue of their acknowledgement of several chronic and acute conditions, rarely suggested that they sought a means of obtaining long-term care or another form of institutional health care.

A different aspect of the elderly homeless' health status may be assessed by questions directed toward the use of and need for supportive or prosthetic devices. While the original set of questions regarding the use or need for such devices included fourteen items, only three elicited significant (more than 4 affirmative) responses. Sixteen respondents used denture plates, fourteen used a walking cane, and sixty-eight (82% of the sample) required eye glasses. The majority of respondents (71%) indicated that they were in need of new or more adequate devices, virtually always this need was expressed as eye glasses or dentures.

MENTAL HEALTH STATUS

It is frequently claimed that many of the homeless in urban areas are former mental hospital patients, discharged in national efforts to either receive more humane or appropriate care in the community or to shift the financial burden from state budgets to the federal Medicaid program, depending upon the observer's point of view. In the recent Chicago study about one third of the homeless were found to have had previous institutional mental health experience and we know from the earlier chapter on institutionalization that our sample of elderly Detroit Homeless appear to also have had about the same mental health inpatient history. Several questions in the current study pursued the question of mental health status beyond the initial questions that focused on prior admissions to a state mental hospital. This chapter will discuss these questions.

Tables 4. and 5. (presented earlier) and Table 12. (below) display information regarding mental hospital admissions and other mental health center inpatient treatment. Table 12 is based on the more conservative of the two methods of inquiry, from our second question dealing with mental hospitalization. It is apparent that between 26% and 33% of our total sample has had previous inpatient experience in a state mental hospital and that this is more likely among women than men and white rather than black elderly homeless.

It is also clear from these data that mental health treatment experiences are only recent for a small minority of the elderly homeless in this sample. Only 10% of the total sample reported that either admission to a state mental hospital or treatment in a mental health center had been within the last year. Although this number is small it may suggest, given the relatively high level of previous treatment within the mental health system, that a larger proportion of these elderly might have been eligible and perhaps appropriate for mental health services during the last twelve months than actually used such services. All investigations of the homeless, regardless of age stratification, have concluded that the need for community based mental health services is greater than the availability or utilization of such services. From these data we concur with these observations.

TABLE 12. PRIOR EXPERIENCE RECEIVING MENTAL HEALTH CARE BY GENDER

A. Prior Inpatient Status in State Mental Hospital (most conservative measure)

	YES	NO	TOTAL
Male	24%	76%	100%
Female	37%	67%	100%
Total Sample	26%	72%	100%

B. In Previous 12 Months: Mental Hospital or Mental Health Center Treatment Experience

	YES	NO	TOTAL
Male	8%	92%	100%
Female	19%	81%	100%
Total Sample	10%	90%	100%

A major dimension of the effects of homelessness upon the individual has been reported to be depression, although the "cause or consequence" controversy regarding this condition has not been fully explored. It is clearly understandable that a combination of pre-homeless experiences with the individual's very marginal status as a homeless person can increase or contribute to a loss of a sense of purpose and self-worth. To examine this condition among the Detroit sample a modified version of the CES-D scale developed by the Center for Epidemiologic Studies of the National Institute of Mental Health was used to measure levels of depression. For purposes of this initial report only the proportions of responses to individual items will be presented. Further analyses of these data will be forthcoming. The individual item results are presented in Table 13.

TABLE 13. RESPONSES TO DEPRESSION SCALE ITEMS, BY GENDER

In the last week have you had or felt ... ?

(Question 41 in the the field instrument)

	Never	Some of the Time	Most of the Time	Total
A Poor Appetite?				
Male	65%	30%	5%	100%
Female	37%	64%	--	100%
Total Sample	59%	37%	4%	100%
Feel Worn and Tired - No Enjoyment?				
Male	30%	55%	15%	100%
Female	37%	43%	20%	100%
Total Sample	31%	53%	16%	100%
Feel Depressed?				
Male	32%	58%	10%	100%
Female	60%	27%	13%	100%
Total Sample	39%	51%	10%	100%
Unhappy About the Way Your Life is Going?				
Male	23%	43%	34%	100%
Female	27%	40%	33%	100%
Total Sample	24%	42%	34%	100%
Discouraged about the Future?				
Male	32%	41%	27%	100%
Female	57%	22%	21%	100%
Total Sample	35%	38%	27%	100%
Lonely?				
Male	43%	35%	22%	100%
Female	43%	31%	26%	100%
Total Sample	43%	34%	23%	100%

Because of the manner in which the data were developed in the 1986 Chicago study and the frequently referenced Hanes national survey data of the elderly (citation here) an exact

4.

comparison to these results is not appropriate. However, sufficient information is provided to make the following comparisons. First, 3% of the Hanes national sample and 9.8% of the Chicago sample reported having a poor attitude most of the time. This Detroit sample reported 4% and at a very crude level appears to be closer to the Hanes figure than to the Chicago homeless figure. It is important to remember that the Chicago data included all age groups while the Hanes data were specific to the elderly. Secondly, 8.2% of the Hanes data and 14% of the Chicago sample reported feeling tired and worn out most of the time. The Detroit data on this measure is 16%. Third, 14% of the Hanes data and 25% of the data collected by Rossi and his associates reported feeling unhappy about the way life was going for them. The Detroit comparison is 34%, the highest of these three samples.

Continuing this comparison, 58% of the Hanes sample reported never feeling discouraged about the future while 29% of the Rossi sample and 35% of the Detroit sample were never discouraged about the future. Finally, 75% of the Hanes respondents reported never feeling lonely. Of the Chicago homeless respondents, 40% reported never feeling lonely and in our sample 43% indicated that they never felt that way.

These results indicate at a preliminary level of analysis that in five out of six measures the Detroit elderly homeless respondents reported in a highly comparable way to the Chicago homeless sample. These measures suggest a high prevalence of demoralization and depression among the homeless elderly in Detroit. Such a finding is not unexpected, given the circumstances in which our sample lives. At the same time, the results raise serious questions as to the efficacy of existing programs in meeting the mental health needs of this special population. Without clear and effective procedures and programs to combat the mental effects of homelessness, or the emotional pre-conditions that are associated with becoming homeless, we are less than optimistic about the ability of large numbers of these people raising themselves out of their current conditions.

In summary, the mental health status of the elderly homeless of Detroit, like their physical health, is marginal at best. About half of this sample have been hospitalized within the last twelve months and one third have received medical assistance in the last month prior to the interview. Furthermore, medical assistance is frequently not available when needed by these people. Women generally use more health care services than men and apparently have greater need for them. It would appear that dental problems, arthritis and hypertension are the most commonly reported chronic health problems in this sample and between 26% and 32%, a significant proportion, have had inpatient experiences with state mental hospitals, with depression continuing to affect them.

THE FEAR AND REALITY OF CRIMINAL VICTIMIZATION

More than most residents of Detroit, elderly homeless people are fearful of crime, dangerous streets, and dangerous situations in which they spend their lives. The information regarding this sample's experience with criminal victimization suggests that their fear of crime is justified. The interviews included four questions that explored each respondent's fear of being a victim of crime, personal experiences as a victim, and fear of being a victim again in the future. As the data presented below demonstrates, these respondents have had substantial personal experience with material losses and violence. In this sample 51% of all respondents had been victims of crime in the twelve months prior to the interview. Analyses of specific criminal victimization will be based on statistical analyses of thishalf of the sample. Differences between the younger and the older homeless elderly, and other subgroup distinctions will be presented.

Of the total sample, 19% stated, in response to the question, "When you are out on the street or in the community are you afraid of being hurt, robbed, or abused by someone?" that they were fearful "all the time." Another 18% indicated that they were afraid "most of the time" and 21% selected the response that they were only fearful "sometimes." This 56% of the sample is in contrast to the remaining respondents and is associated with the finding that in the subsequent question over half indicated that they had been a victim of crime within the last year. Of these recent victims of crime, 56% had been robbed, 32% had been beaten or physically hurt, over 10% had been raped and 15% had been deprived of legal rights. These are clearly people at risk with almost 60% of these recent victims fearful of being the target of crime again. Thirty-five percent of the sample was a victim of robbery and a violent crime more than once during the last twelve months.

Table 14 displays criminal victimization for recent victims by age groups. Within this sample the 65 to 74 year old respondents were most frequently victimized and 43.7% of this age group had indicated that they were fearful "all the time" or "most of the time." Their fear appears to be based on personal experience. It is clear from this table that the older homeless elderly have been more vulnerable to crime than the younger respondents (those under 65 years old).

TABLE 14. FOUR CATEGORIES OF CRIMINAL VICTIMIZATION BY AGE

(Only Including Respondents Victimized Within 12 Months)

In the last year have you been...	**Age Groups**					
	54-64		**65-74**		**75-86**	
	n	**%**	**n**	**%**	**n**	**%**
Robbed?	1	33.3	25	45.5	12	44.4
Beaten/Physically Hurt?	-	--	15	27.3	7	25.9
Raped?	-	--	3	5.5	4	14.8
Deprived of Legal Rights?	-	--	8	14.5	2	7.4

When the victimization data are analyzed according to gender, certain distinctions are apparent that present a disturbing picture of the brutality of being elderly and homeless in Detroit. Among the men, one third expressed a fear of being a victim of crime "all the time" or "most of the time." The comparable figure for the women was 47%. The sample's actual experience with crime demonstrates gender-specific differences, as presented in Table 15. In the sample 50% of the men and 51% of the women reported being a victim of crime within the previous 12 months. There was little difference regarding robbery in which 45.5% of the men and 47.1% of the women were robbed. Similarly, 27.3% of the men and 23.5% of the women had been beaten and physically hurt.

Gender differences became significant, however in the other categories in which, as expected, only two men, or 3% reported being raped and 29.4% of the women reported being raped. Two women indicated that they had been beaten while raped on four occasions and hospitalized subsequent to each attack. Only 5, or 7.6% of the men indicated that they had been deprived of legal rights during the last year, while 23.5% of the women remembered this form of victimization. It is important to remember that the smaller sample of women has an inflating statistical effect on these percentages; the principal finding, however, that women are at significantly higher risk for rape and deprivation of legal rights cannot be disputed. While over half (51.5%) of the men reported that they feared being a victim of crime again, only 35.3% of the women respondents indicated this fear. This distinction is difficult to interpret and may reflect a higher level of mental health problems among the women. Their objective risk of harm in their circumstances would suggest a higher level of concern regarding repeated victimization.

TABLE 15. FOUR CATEGORIES OF CRIMINAL VICTIMIZATION BY GENDER

In the last year have you been ...	Male		Female	
	n	%	n	%
Robbed?	30	45.5	8	47.1
Beaten/Physically Hurt?	18	27.3	4	23.5
Raped?	2	3.0	5	29.4
Deprived of Legal Rights?	5	7.6	4	23.5

Racial differences among the victims of crime in this sample are presented in Table 16. One third of the white respondents and 38.4% of the black respondents said that they fear being the victim of crime "all the time" or "most of the time". One of the three hispanic respondents indicated this level of fear. By contrast 51.5% of the white respondents and 51.1% of the black respondents had been a victim of crime during the twelve months prior to the interview, as had one of the hispanics. In general terms this indicates no racial differences. At a more specific level, however 54.5% of the white sample compared to 40.4% of the black sample had been robbed during the previous year. Nine of the white respondents (27.3%) had been beaten and physically hurt as had 25.5% of the black respondents. Of the seven victims of rape, six were white (five women and one man). One black woman had been raped. Of the multiple rape victims, one was black and one was white. Fifteen percent of the white respondents told interviewers that they had been deprived of legal rights which is almost twice the proportion as found in the black sample in which 8.5% indicated that they had been so deprived. The definition of "legal rights" may not have been exactly comparable among all members of the sample, however, and this may require further study to interpret. It may be that the white respondents were more sensitive to the deprivation of legal rights or black respondents may have not regarded some offenses against them to qualify as reportable in the interview. The one hispanic victim of crime had been robbed and beaten on each of three occasions. Virtually identical proportions of black and white respondents, 49%, told interviewers that they feared being victims of crime again.

TABLE 16. FOUR CATEGORIES OF CRIMINAL VICTIMIZATION BY RACE

In the last year have you been ...	**White**		**Black**	
	n	**%**	**n**	**%**
Robbed?	18	54.5	19	40.4
Beaten/Physically Hurt?	9	27.3	12	25.5
Raped?	6	18.2	1	2.1
Deprived of Legal Rights?	5	15.2	4	8.5

Reported victimization of specific crimes was compared to reported income of the homeless victims and no patterns were identified. Victimization was not clearly a function of relatively more income or relatively less income within this special population.

HOMELESS OR NEARLY HOMELESS - THE SUB-MINIMALLY HOUSED

During the field work, including both phase one during which candidate data collection sites were selected and phase two in which respondents were identified and interviewed, the field team encountered situations and individuals that suggested that a large number of elderly Detroit residents live in boarding houses of questionable adequacy or decency. Indeed, the number of elderly people of obvious poverty living in boarding houses that are crowded, filthy, and below an acceptable level of adequacy may number in the hundreds in certain neighborhoods.

It remains to be determined, probably in a separate and detailed investigation, if the persons we encountered are largely deinstitutionalized from mental hospitals or other institutions, however it appeared in numerous occurrences that the majority of these elderly were of significant mental and physical vulnerability. At one such establishment three residents informed the Principal Investigator that the owner held a Power of Attorney and "collected our Social Security checks to protect us from getting robbed. Then [she] gives us a twenty [$20) for the month for spending money. She takes good care of us, you know it." (July, 1988)

Many of the initial contacts with elderly persons in food services or other places in which we identified, screened and interviewed people actually were housed in boarding houses. Because they were housed and not appropriate for this study, extensive data were not collected from them, however, their condition and the condition of the places in which they live strongly suggest that they are victims of exploitation and, we believe, are at risk due to the limited options that appear to be available to them.

It is equally clear to us that the large numbers of these individuals would swell the homeless elderly population in Detroit were it not for the boarding houses and, however indecent, the services that are acquired in these places. The need to fully understand the condition of the elderly poor residents of boarding houses in Detroit, the financing of these places, and the proportion of total income that the residents pay for minimal shelter and food should become a high priority for all public and private services that are concerned with Detroit's elderly.

NOTES FROM THE FIELD, OR: A VIEW FROM THE STREET.

It would not be adequate to conclude the presentation of the basic findings and initial analyses of this study without providing a more intimate perspective of the encounters and people who were interviewed. This more human side of the effort left the field team exhausted and profoundly affected during the course of our data collection. Presented below are a sampling of the people and circumstances that typified the data collection effort and the stories that are poorly abstracted into operationalized variables.

The man whose face moved was 73 years old. A white man with a prison record for homicide in 1952 in Texas. His face moved because of the enormous population of body lice that literally covered his skin; an infestation to which he was oblivious. His clear eyes never failed to maintain contact with the interviewer and his answers were articulate and thoughtful. In his words, "I screwed up when I was younger and I guess I'll never live it down. Nobody in my family wants anything to do with me. I have a daughter and I think I'm a grandpa, now, but I'll never see my grandson. I think it's a boy; one of my friends at Kelly's place knew my son-in-law and told me about it. I drink a lot sometimes. You know, a little fortification...The worst thing that happened to me was when I got beat up and put in the hospital. I heard those nurses saying I was goin to die, but I didn't." This man spent the previous night at a shelter, on the street called Kelly's, and apparently carried his horde of lice into the shelter and out again without any attempt to be freed of his infestation. He was typical of elderly men with prison experience who were returned to a society in which they were unwanted and for which they were unprepared.

A woman at a meal program who was an immigrant in 1944 from Germany, via England and Jamaica, explained that she was doing fine in Detroit until her husband died and left no pension. She found part time employment and managed to maintain her home, near the Fort Street General Motors plant, until her dog annoyed the men who lived next door. In her words, "When my dog barked at them, one night they ran over her with their car and threw her up on my porch. I called the police and made a complaint. One of them was arrested. But then when I came home one afternoon three of them came right into my house and they hurt me pretty bad, you know they raped me, each one of them and then they kicked me and I had to go to the hospital. Well when I came home my house was burned up. I slept there for a few nights, right in the mess. I didn't have any home any more...That was last winter, then I went back and the guy that ran over my dog beat me up and raped me...I didn't call the police, I just went to the church and got cleaned up and then I stayed there for a while. My daughter in the suburbs, she wouldn't want me to be with her."

This woman was typical of other women in the sample except that she was unusually lucid and able to provide details of past events. The interview lasted over one hour, with over twenty minutes devoted to her explaining why she couldn't provide only one "worst thing" that had happened to her.

The elderly homeless who were interviewed in this study were hard to find, difficult to identify, and after the interview they would disappear into the city. In front of one abandoned building in which two elderly men had been living, steam from a manhole cover was rising in early morning air. The homeless elderly living in that neighbor-hood were like that column of steam, quickly dissipating and becoming invisible.

Each of the field team members noted that respondents were generally able to respond to a sense of humor and were able to express optimism and hopefulness during the interviews. Few of the respondents were aggressive, although at one meal site over a dozen elderly men who were probably homeless refused to be interviewed.

During the weeks of fieldwork the phrase "doin' the routes" became a meaningful description of the most typical daily routine for many of our respondents. The team met and revisited several respondents that appeared at meal sites or shelters in different neighborhoods and sections of the city. It appears to us that "doin the routes" is a necessary journey for many of these people who gather their food, clothing, health care and satisfy their other needs from a loosely connected network of charitable services that are scattered throughout the city. The ability of these people to understand the weekly, monthly, and less regular schedules of different services, free meals, or free clothing and shoes and to be able to arrive on time at the right place and the right day was evidence enough to the field team that survival as a homeless person demands a specialized knowledge of the city that few human services workers have committed to memory.

In these notes about the field experience, it is appropriate to introduce Mr. Lewis, a man who has spent several years rolling cigarettes by hand to sell for three cents apiece in meal programs and shelters. This is his only source of income. Mr. Lewis's cigarettes are, moreover, rarely smoked immediately. Instead, among the elderly homeless, cigarettes have become currency in a token economy that is remarkably like the cigarette economies of World War II prisoner of war camps. Among the young and elderly homeless, services or items are exchanged for cigarettes after a price is negotiated, after the cigarettes are examined for their condition, and if manufactured or hand rolled. This token economy is a metaphor for other exchange mechanisms at this level of poverty, including practical information about places to sleep or to find food, sources of medical care, beverage alcohol to be shared, or situational group affiliation in a makeshift shelter, abandoned room or even in a formal shelter in exchange for more security and safety than being alone.

Finally, it would be a grave oversight if the field experiences from this study failed to note the heroic and remarkable people who serve the homeless throughout Detroit. In our minds these are actually "Detroit's Finest." In soup kitchens, shelters and missions in this city there are a rare breed of people who serve with no notice by the rest of us, but who are loved by the poorest of the poor. In hot and inadequate facilities, often in basements of ancient buildings, food is prepared for hundreds of people every day. Early in the morning volunteers go to work for the homeless and throughout the day serve these nameless crowds with only a lingering eye contact as their reward. But in that eye contact, for those who can see it, is a deep message of thanks. We think that the difficulties faced by the homeless, especially the aged homeless, would be largely eliminated if more of us could understand that simple message.

CONCLUSIONS AND RECOMMENDATIONS

The conclusions to be drawn from this study will be presented below, accompanied by a summary of the most important objective findings. Our understanding of the pathways into and out of homelessness among these elderly people will be discussed on the basis of our observations and the observations of others, principally in recent research in Chicago. And finally, our recommendations for service, research and public policy will be presented, keeping mindful of the need that we have previously acknowledged to further analyze these data for additional and more detailed insights.

The most fundamental finding of the research is that the elderly homeless in Detroit live in a state of gnawing poverty and isolation that only a small minority of Americans ever imagine. The fact of survival for many of our respondents is a direct result of charitable food, shelter from the elements, and free medical care. Death from exposure, starvation and the meanness of the streets would surely claim more of these lives if the charitable safety net was not there. But this safety net is hard, and the conditions in which these people live is a disgrace and a source of shame. The needs that demand attention and the prevalence of homelessness among the elderly are not nearly so great that better conditions for them are beyond our collective ability to provide. All that is needed is a consensus of our collective will.

Rossi and his associates in Chicago summarized their principal findings which are in substantial agreement with ours. The principal measured characteristics of Detroit's elderly homeless will be presented along with the comparable points from Rossi's data.

> Survival dependent upon charity was found in both studies. Homeless elderly people are profoundly poor.
>
> A small proportion of respondents in both studies received any regular income from an income maintenance program. We suspect, principally from the age distribution of the Detroit respondents and our observations of large numbers of older people living in boarding homes that Social Security benefits become a

source of relative stability for homeless people who survive to age 65. As noted below, eligibility for Social Security benefits may serve as a way out of the cycle of homelessness for many elderly people.

In the most hospitable weather, as was the case during our weeks in the field in June, July and August, 1988, few elderly homeless seek shelter in formal temporary housing that is designed to serve the homeless. Rossi and colleagues noted that this remained true in months with fierce Chicago winter weather. Elderly homeless are the least likely to seek out these shelters in all seasons. One explanation, from comments made by the Detroit respondents, is that elderly homeless fear younger people who congregate in the shelters. We do not know if this fear is based on experience, however, we do know that the elderly homeless in Detroit have had substantial experience with criminal victimization and may have reason to fear younger people. The elderly homeless are more likely to be found in a variety of places that are not formal shelters for the homeless.

Elderly homeless people have a high prevalence of physical and mental illness and are generally in poor health. Depression is prevalent and most have had substantial previous experience with hospitalization and clinical medical services. A majority of elderly respondents have numerous unmet medical needs of both an acute and chronic nature.

It is not true that most of the homeless elderly in Detroit are deinstitutionalized mental patients. This was also true in Chicago. It is true, however, that the majority of the homeless have had substantial institutionalized experiences that include periods of time in mental hospitals, jail, prison, or alcohol and illicit drug detoxification. Many elderly homeless men have had experiences with reduced personal liberties due to probation. White homeless elderly people are more likely to have been mental hospital inpatients than others while black homeless elderly are most likely to have served time in jail or prison. White women who are homeless are most likely to have been mental hospital patients. These findings are consistent with the observations of Chicago's homeless population.

The elderly homeless are generally alone, without substantial or available kinship or other social relationships. Friendship relationships are far more commonly reported than family support, however, the meaning of such friendship ties in terms of durability and practical assistance is not clear. A high proportion of the elderly homeless have never been married or are divorced or separated. A majority have never had a nuclear family experience as an adult. White elderly homeless were twice as likely than others to have never been married while black elderly homeless were three times more likely than white respondents to have been widowed. Burkhauser, Holden and Feaster (1988) have noted that widowhood is rarely a direct cause of poverty after retirement. We suspect, however, that these cases of black elderly people were pushed into poverty and homelessness by the loss of their spouse, accompanied by insufficient alternative supportive resources of either money or other assets. Steady and sufficient employment is either not available to them, or the elderly homeless are unable to maintain adequate compensated work. A small proportion of the Detroit respondents receive ongoing compensation from work. This was also found to be true in Chicago and is not an unanticipated finding.

The ages of elderly homeless are more often consistent with the concept of being "young old rather than "old old." The importance of this finding and its implications for policy will be discussed below.

Homeless elderly people, like most of the general homeless population, are usually men. Black homeless elderly are over represented and white and hispanic groups are under represented. This suggests a higher risk of becoming homeless among black men than any other subset of the population.

Elderly people who are homeless are, generally, poorly educated and are unlikely to have substantial skills that could be readily utilized in the current labor force. High levels of substance abuse treatment and detoxification, criminal records and mental hospitalizations also preclude many employment opportunities that might be available for other people of similar age, race and educational accomplishment.

Other findings that are more specific to the present study in Detroit, include our observation that the elderly homeless in this city are frequent victims of crime, including loss of property and money and being physically attacked. The fear of crime among respondents in this sample was high and it appeared to be justified on the basis of experience.

Few of the respondents in this study migrated to Detroit from somewhere else, neither from another city nor from state or region of the country. Usually life long Detroit residents, it would appear that a lack of familiarity with the city and its resources is not a singularly critical factor in the causes of homelessness for these people.

While not, technically, homeless there is a large and undocumented population of very old, impoverished people living in Detroit's boarding houses. These private services accomplish keeping many vulnerable people from being on the street, however, we question the quality of life, the safety and decency of the majority of these businesses, and believe that there is, at least, a high probability that the residents are frequent victims of exploitation. We came to refer to the people who live in these boarding houses as the sub-minimally housed as they were screened from the sample; we still found them at places where free food and clothing were offered. Even the homeless refer to the boarding houses as "warehouses."

Keigher,in her 1987 study of the homeless elderly in Chicago, insightfully noted that being housed or homelessness among the poor elderly is a continuum that is largely determined by the individual's resources. The resources, in this social formula for the very poor, refer more often to kinship and interpersonal linkages than to monetary wealth. Noting that all very poor people are not permanent street people, that even street people are intermittently housed, and that most homeless do not sleep on the streets or in parks most of the time suggests that for these people, all personal resources are used to acquire basic needs such as food and shelter. Such resources are used immediately, in that there is usually an urgent need. The importance of institutionalized experiences with the elderly homeless or minimally housed is that these episodes in these peoples' lives are indicators of meager interpersonal and kinship resources. It is the lack of "interpersonal wealth" of the elderly poor that, we suggest, determines the probability that homelessness can become an oppressive fact of life.

PATHWAYS INTO AND OUT OF HOMELESSNESS

Among this sample of elderly homeless people we found a few recurring themes that may guide future studies toward an improved understanding of the causes and ways out of being homeless in old age. Most of the respondents in this study have had bad luck most of their lives. Very few respondents suggested that singularly catastrophic events led to their marginal status. Some indicators, however, do suggest that sentinel events, as consequences of preceding behaviors and circumstances, may be predictive of the homeless condition.

These events include:

> Being deinstitutionalized at age 50 or over from a mental hospital;
>
> Being released at mid-life or later from a prison (particularly after a long sentence);
>
> Being an alcoholic or drug addict with little or no success in detoxification or treatment;
>
> and, being abused and abandoned, after being exploited by family members.

Some events that are specific to the larger issue of housing did emerge as important, particularly the loss of a home due to fire, however as a singularly important cause of homelessness, at least for this aged population, other more complex combinations of problems appear to be more significant. Clearly with a population at risk, the precipitous loss of a home, loss of assets, and inability to afford any housing that is available can lead to homelessness. We feel, however, that the long term homeless condition of the majority of these elderly respondents suggests that life-long difficulties with other people, lack of a supporting family, poor education and lack of job skills, and personal problems such as alcohol abuse and criminal behavior are far more likely to be pathways into homelessness. Poverty, in association with these other problems, is the one single factor that can turn someone onto the street. Other factors that complicate a way out of poverty will keep that person on the street.

Ways out of homelessness for the elderly are not complicated. Death from exposure and the health hazards of hardship, poor nutrition and physical trauma may be the most likely way out of the condition for elderly people. Keigher has noted that her ability to find elderly homeless people in Chicago one year after a previous interview has frequently been frustrated by the death of the respondent. Another way off the streets is by survival. By this we refer to the arrival of age 65 and eligibility for Social Security benefits. This source of regular and predictable income may mean that a homeless older person can acquire and remain in a boarding house, a single room occupancy hotel, or an apartment for the first time in years. This does not imply that this person suddenly exits from being vulnerable to the consequences of being homeless and aged, nor from risk of exploitation of his or her newfound resources.

A third way out of homelessness, at least in Detroit, for the elderly may be by virtue of an acute hospitalization that is followed by a nursing home placement that is facilitated by a discharge planner in the hospital. In 1988 Douglass and his colleagues found that in Detroit, Medicaid nursing home beds were unusually likely to be filled with elderly black males (Douglass, et al., 1988). We suspect that many of these elderly men were homeless prior to their hospitalization and are unlikely to return to a homeless condition because they will remain in the nursing home until they die. We are suggesting, here, that two of these three pathways out of homelessness for the elderly include death or serious medical impairment. Because of this pessimistic prognosis, we suggest that ways to prevent homelessness among the elderly are more significant as a class of appropriate responses to the issue.

RECOMMENDATIONS

We suggest that three areas of recommendations are appropriate for the issues and problems raised in this report. The analyses that will continue with the current data may modify or add to this list of suggestions, however the basic distinctions between recommendations for service, public policy or research will not be changed. Our recommendations will begin with those of service for programs and agencies, then for public policy. These will be followed by research questions and projects that are suggested by the present analyses.

SERVICE RECOMMENDATIONS

Although housing, per se, is probably tangential to the causes and contributing factors to the persistence of homelessness among the elderly, it is clear that affordable, clean, safe and acceptable housing alternatives are insufficient within Detroit for the very poor. It is recommended, therefore, for at least immediate relief from the acute risks of homelessness and sub-minimal housing status that an aggressive subsidized housing program be initiated immediately. Such housing should be designated for the very poor elderly and should include in-residence supervision, social and health services, and on site nutrition programs. The nutrition, health and social services should be licensed by the State of Michigan and the housing program should be closely monitored and supervised to ensure that it provides a secure and safe residential environment. It is recognized that Detroit, unlike many large cities, does not have a surplus of large multi-unit residential buildings that are appropriate for conversion to this purpose and that some means of new construction may be required to enact this recommended service. This may provide an opportunity for a public and private sector collaboration to serve a highly at risk population.

The best opportunity to effectively deal with homelessness among the elderly is to prevent individual elderly people from becoming homeless in the first place. It is clear from our analyses that discharge from mental hospitals and release from prisons are two sentinel events that appear to precede homelessness. We suggest that after-care services for both released mental patients and prisoners be developed to assist these people with the development of social, interpersonal, and other skills that will enable them to re-enter the world that they left behind. The possible argument that this type of intervention is prohibitively expensive should not be considered valid in that such services are likely to reduce dependency on charity and public assistance in the long run.

Elderly people who are homeless are frequent victims of crime. We recall the physical and emotional conditions of the homeless elderly in the present study and find it appalling that these people are in such danger on a relatively constant basis. We suggest that special crime prevention units be developed by the Detroit Police Department, in association with the other crime prevention activities of the Department, and that these specialized units identify risk factors associated with property and violent crimes against the elderly homeless while designing methods of reducing this problem. Persons who are culpable of crimes against the homeless elderly should be vigorously prosecuted.

The elderly homeless present a unique set of physical and mental illness. Dental care, optical care, podiatric care, and problems such as pediculosis infestations are debilitating to the elderly homeless. These, along with other problems of acute and chronic disease require medical services that are available and appropriate for this special population. Existing health care for the homeless in Detroit should be expanded to more adequately accommodate the specific priority medical needs that have been identified in this analysis. Further, mental health services should be included in the comprehensive health care programs for the homeless elderly.

PUBLIC POLICY RECOMMENDATIONS

The State of Michigan should account for the status and condition of all persons who have been released from State Mental Hospitals into the communities of Michigan. Particularly for older residents of State Mental Hospitals, it is important to understand what has happened to these people subsequent to their release. Did they move into adult foster care facilities, nursing homes, or group homes? How many have walked away and out of the supervision of the

State? What proportion of the people released from state hospitals have become homeless and dependent upon charity for survival? What is the State's responsibility to fully understand and document the consequences of the deinstitutionalization policies of the last twenty years regarding the well being of the patients who have been discharged?

Boarding houses, a private entrepreneurial service to hundreds, perhaps thousands of very poor elderly persons in Detroit, are largely undocumented, unregulated, uninspected and uncontrolled. To an extent these places keep many elderly from becoming homeless, yet, from our observations in the field, these places also are far from adequate housing. Those that provide meals should have the quality and adequacy of the food regulated. The physical condition of the buildings and resident rooms should be within an acceptable level of cleanliness, safety, and dignity. In that the majority of the residents of these business establishments are very poor, elderly, and frequently in poor mental or physical health, the appropriateness of these environments for a population at risk should be a priority topic of debate by City of Detroit, Wayne County and State of Michigan leaders. Is this the safety net of choice for vulnerable elderly who are at risk of being homeless?

The traditional role of alcoholism is an important feature of many of the elderly homeless in Detroit. The adequacy of outreach, referral, inpatient and outpatient substance abuse treatment services, including detoxification services, for this population should be reviewed. Also, associated with alcohol abuse and alcoholism, the density of retail alcohol beverage licenses within the City of Detroit should be reviewed in light of general depopulation in recent years. Recent research conducted for the Office of Substance Abuse Services has identified the density of such retail outlets as highly predictive of places in Detroit where cirrhosis mortality is high. Elderly homeless people who are alcoholic are traditionally and currently at risk of mortality and costly health care needs associated with alcoholic cirrhosis.

RESEARCH RECOMMENDATIONS

The current study should be replicated with a larger sample and, as did Rossi and associates in Chicago, during the harsh months of winter. The nature of the homeless elderly and the duration of their homelessness over the annual cycle should be investigated to understand how and when to provide intervention and prevention services to this population.

Comprehensive health status, including substantial laboratory, physical examination, mental health examinations and medical history should be conducted to provide a basis for the expansion of health care services for the elderly homeless. These studies should be associated with psychosocial studies that will identify relationships between physical and mental health with personal and family histories, involvement with substance abuse or criminal behavior, domestic violence, unemployment and other social and behavioral problems.

Comprehensive "follow-back" studies should be conducted with elderly homeless people to identify sentinel events that contributed or precipitated their homelessness. Such studies may contribute to the identification of a set of more narrowly defined targets for social or interpersonal change that might mitigate the problem of homelessness among older persons in the future. The current state of the art provides an enormous range of potential points of intervention with little understanding of the relative potential efficacy of any given approach.

The homeless elderly present an opportunity to investigate the limits of the human ability to remain hopeful and resourceful in the face of ultimate personal challenges. How the elderly homeless learn to survive, to "do the routes", to remember where and when to obtain charity services, and to find methods of surviving with no usual resources are important questions.

Finally, the acceptability of alternative services, housing and shelter arrangements, and other proposals to help the elderly homeless should be considered and measured with primary data from the potential recipients, themselves. The reasons for homelessness among old people are complex and should not be assumed to adhere to rational behavioral expectations. Public investments to reduce the environment of poverty within which the homeless live may be as instrumental in reducing this particular problem as any project directed specifically to the homeless elderly.

FINAL COMMENTS

In concluding this discussion, we would urge the reader to consider the fundamental issues of homelessness and vulnerable elderly people to be interrelated with larger considerations of poverty, desperate life styles, isolated people within the urban center, and the lack of concern for the status of poor people by the larger society. We were profoundly affected by the people who were interviewed in this study and confronted by the degree with which our social and health care services have failed to reach these people in an adequate way. To the extent that the design and delivery of health and human services reflect the values of the larger society, it is clear that the continuing crisis of homelessness, and particularly homelessness of aged people, has not yet become a problem of intolerable proportions to the majority of the population. It is our hope that this report has presented a sufficiently vivid image of being aged, adrift and alone to stir our society toward an appropriate and compassionate response.

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APPENDIX A

COMPARATIVE HIGHLIGHTS OF MAJOR REFERENCES

APPENDIX A

Study Number 1.

Roth, Dee., Jerry Bean, Nancy Lust and Traian Saveanu.
Homelessness in Ohio: A Study of People in Need.
Statewide Report. February, 1985.

Methods of Classifying Sample:

Total homeless persons surveyed: 943 Ohio Residents.
The classifications used reflect the respondents level of exposure to the elements.

Street people n = 139.
Shelter people n = 562.
Resource people n = 242.

Emphasis of Study:

To describe characteristics of homeless people, particularly those who might be mentally ill. The general categories of information collected about the respondent group included:

- homeless condition
- history of psychiatric hospitalization
- employment history
- social support
- general well-being
- Use of social services
- income
- medical problems
- demographic information
- current mental health status

To examine, on the basis of the above information and through data collected from Ohio state psychiatric facilities and selected community mental health centers, if and how mental health policies and efforts to deinstitutionalize mental hospitals may have contributed to the homeless population in Ohio.

Study Number 2.

Rossi, Peter H., Gene A. Fisher and Georgianna Willis.
"The Condition of the Homeless of Chicago:A Report Based on Surveys Conducted in 1985 and 1986".

Methods of Classifying Sample:

Total homeless persons survey of 563 Chicago residents classified into:

Street Sample n = 50.
Shelter Sample n = 513.

Primary Emphasis of Study:

There were four main goals of the Chicago Homeless Study:

1) To develop and test methods for conducting unbiased surveys of homeless people that could be used in any city and could be generalized to make estimates for the entire nation.

2) To describe the social conditions under which homeless persons in

Chicago lived.

3) To describe the social and demographic composition of the Chicago homeless.

4) To estimate the size of the Chicago homeless population.

Study Number 3.

Keigher, Sharon M.
"The City's Responsibility for the Homeless Elderly in Chicago".
Gerontological Society of America. Final Fellowship Report., Nov. 1987.

Methods of classifying sample: None.

Emphasis of Study:
Agency and 45 key informants provide descriptions of 125 elderly homeless clients. Files were reviewed by three ancillary agencies. Contrasting the differential needs of shelter vs. non-sheltered people.

Study Number 4.

Appleby, Lawrence and Prakash N. Desai.
Documenting the Relationship Between Homelessness and Psychiatric Hospitalization. Hospital and Community Psychiatry.
July 1985, vol 26, no 7, p 732-736.

Methods of classifying sample:

The records were classified into the following:
State Facilities.
Region 2 Facilities.
Chicago Road Center.

Emphasis of Study:
To document the relationship between psychiatric hospitalization and homelessness in Chicago.

Study Number 5.

Koegel Paul, Rodger K. Farr and M. Audrey Burnam.
"Heterogeneity in an Inner-City Homeless Population: A Comparison Between Individuals Surveyed in Traditional Skid Row Locations and in Voucher Hotel Rooms". Psychosocial Rehabilitation Journal: Oct. 1986, Vol. X, Number 2, p 32-34.

Method of Classifying Sample:

Total homeless persons surveyed 379.
The classifications used:
1) Skid Row.
2) Non-Skid Row.

Emphasis of Study:

Comparison of the two groups revealed significant differences in demographic characteristics, subsistence patterns, and current psychological distress, few differences in mental disorder.

Study Number 6.

Robertson, Marjorie J. and Michael R. Courineau.
"Health Status and Access to Health Services among the Urban Homeless"
American Journal of Public Health. May 1986, vol. 76, no. 5, p 561-563.

Method of Classifying Sample:

Total homeless persons surveyed 238.
The classifications used:

Skid Row Sample	n = 73%
Other Coastal Community	n = 27%

Emphasis of Study:

Probing history of homelessness, demographic characteristics, health status, health problems, access to health care and utilization.

Study Number 7.

Gelberg, Lillian, Lawerence S. Linn and Barbara D. Leake.
"Mental Health, Alcohol and Drug Use, and Criminal History Among Homeless Adults".
American Journal of Psychiatry, Feb. 1988, 145:2, p 191-196.

Method of Classifying Sample: None.

Total homeless persons surveyed 529.

Emphasis of Study:

Demographics grouped according to their previous use of mental health services, i.e. Out patient group and non-utilizer group.

Study Number 8.

Sacks, Joseph M., John Philips and Gordon Cuppelletty.
"Characteristics of the Homeless Mentally Disordered Population in Fresno County". Community Mental Health Journal. Summer 1987, vol 23, no. 2, p114-119.

Method of Classifying Sample: None.

Total homeless persons surveyed 61.

Emphasis of Study:

Characteristics sought. As a needs assessment for a publicly funded program.

Study Number 9.

Dorwart, Robert A.

"A Ten Year Follow-up Study of the Effects of Deinstitutionalization."
Hospital and Community Psychiatry. March 1988, Vol 39, no. 3, p. 287-291.
Method of Classifying Sample: None.

Total homeless persons surveyed:
In 1977 n = 137.
In 1987 the patient population was 7.

Emphasis of Study:
The effects of deinstitutionalization and what findings suggest. This was a resurvey to find out the changes in the clinical characteristics of the patient population between 1977 and 1987.

Study Number 10.

Cohen, Carl I., Jeanne Teresi, and Douglass Holmes.
"The Mental Health of Old Homeless Men."
American Geriatrics Society. June 1988, Vol 36, No. 6, p 492-501.

Method of Classifying Sample:

Total homeless persons surveyed 281.
Street People
Non-Street People

Emphasis of Study:
Addressing issues concerning the mental health of aging homeless men.

Study Number 11.

Cohen, Carl I., Jeanne A. Teresi and Douglass Holmes.
"The Physical Well-Being of Old Homeless Men."
Journal of Gerontology. 1988, Vol. 43, No. 4. p 5121-5128.

Method of Classifying Sample:

Total homeless sample used 195.

Emphasis of study:
How do the physical health of skid row men compare with men in the general population.

Study Number 12

Cohen, Carl I, Jeanne Teresi, Douglass Holmes, and Eric Roth.
"Survival Strategies of Older Homeless Men."
The Gerontologist. 1988, Vol. 28, No. 1, p 58-64.

Methods of Classifying Sample:

Total homeless persons surveyed 281.
Street people
Non-street people

Emphasis of Study:

Describes ability to procure basic necessities such as money, food, shelter, and health care. Insight on how one segment of the aging population has managed to cope with an environment that is undergoing considerable alterations.

Study Number 13.

Cohen, Carl I. and Jay Sokolovsky.
"Toward a Concept of Homelessness Among Aged Men."
Journal of Gerontology. 1983, Vol. 38, No 1. p. 81-89.

Methods of Classifying Sample:

Total homeless persons surveyed 95.
Bowery men n = 48.
SRO men n = 47.

Emphasis of Study:

Contrasted homeless aged men living on bowery and in single room occupant hotels. Using the Bogue's model of skid row social formation. Findings focus on differences of the two groups, characteristics, mental health, social contacts.

Study Number 14.

Lipton, Frank R., Suzanne Nutt, and Albert Sabatini.
"Housing the Homeless Mentally Ill:A Longitudinal Study of a Treatment Approach". Jan 1988, Vol. 39, No. 1, p 41.

Method of Classifying Sample:

Total homeless persons surveyed 49.
The classifications used:
Experimental group
Control group.

Emphasis of study:

Testing the hypothesis that: (1) It would be feasible to place homeless chronic patients in long-term supportive housing (2) that patients quality of life would be better improved by long-term residential placement then by standard post discharge care. (3) That residential treatment would reduce the severity of patient psychopathology.

Study Number 15.

Lipton, Frank R., Albert Sabatini, and Steven E. Katz.
"Down and Out in the City:The Homeless Mentally Ill."
Hospital and Community Psychiatry.

Method of classifying sample:

Total number of homeless surveyed 100.

The classifications used:
Hospitalized patients
Released patients

Emphasis of Study:

To clarify and understand the problems of the homeless, the authors studied the demographics, characteristics, psychiatric diagnosis and histories of the 100 patients.

Study Number 16.

Kroll, Jerome, Kathleen Carey, Duleie Hagedorn, Peter Firedog and Ellen Banavides. "A Survey of Homeless Adults in Urban Emergency Shelters." Hospital and Community Psychiatry. March 1986, Vol 37, No. 3 p. 283-286.

Method of Classifying Sample:

Total number of homeless surveyed 68.
The classification used:
Shelter Residents.

Emphasis of Study:

Probing central areas deemed essential for the development of services for the homeless. To define who the homeless are and their characteristics and their problems, psychiatric health and what services they are eligible for.

Study Number 17.

Arce, Anthony A., Marilyn Tadlock, Michael J. Vergane and Stuart H. Shapiro. "A Psychiatric Profile of Street People Admitted to an Emergency Shelter." Hospital and Community Psychiatry. Sept. 1983, Vol. 34, No. 9. p 812-16.

Method of Classifying Sample:

Total homeless surveyed 193.
The classifications used:
1) Habitual street people
2) Episodic homeless
3) Individuals not living in street but under acute crisis.

Emphasis of study:

Data keypunched and tabled. Purposes: What departments should be involved and which should have primary responsibility? What were the clinical characteristics of the street people? What sort of program would meet the needs of street people? (To seek a municipal resolution of the problem).

Study Number 18.

Mulkern, Virginia and Valerie J. Bradley. "Service Utilization and Service Preferences of Homeless Persons." Psychosocial Rehabilitation Journal. Oct. 1986, Vol X, No. 2 p 23-29.

Method of classifying sample:

Total number of homeless surveyed 328.
The classifications used:
Homeless found in street n = 155
Individuals enrolled in the (MHS) Massachusetts Department of Health Services n = 46
Individuals using two publicly funded shelters n = 127

Emphasis of Study:

Need assessment results hypothizing that homeless individuals generally want and seek services to meet their needs. Characteristics, psychological health and services sought by individuals are contrasted by statification group.

Study Number 19.

Zipple, Anthony M.
Special Section: NIMH-funded Research on the Mentally Ill Who are Homeless. Psychosocial Rehabilitation Journal. Oct. 1986, Vol X, No. 2., p 3,4.

Mowbray, Carol, Andreau Solarz, Claudia Combs and V. Sue Johnson.
Mental Illness and Homelessness in Detroit Research and Case Studies. Psychosocial Rehabilitation Journal. Oct. 1986, Vol. X, No. 2, p 5-13.

Total homeless persons surveyed 70.

Method of Classifying Sample: None.

Emphasis of study:

This paper reports the results of a study of homeless guests in four temporary shelters in Detroit. The authors conclude that a "comprehensive and coordinated effort is needed by a wide range of service providers to address the needs of this group."

Study Number 20.

Michigan Department of Mental Health.
Mental Health and Homelessness in Detroit: A Research Study. 1983, p 1-23.

Method of Classifying sample: Homeless vs. Non-Homeless.

Total homeless persons surveyed 43.
In the first survey 17.
In the second survey 26.

Emphasis of study:

"The purpose of the residence survey was to determine to what extent homeless or potentially homeless persons accounted for admissions to a large, urban state hospital and to identify those patients so they could later be interviewed." Seasonal variations were considered.

APPENDIX B

FIELD QUESTIONNAIRE WITH MARGINAL FREQUENCIES AND PERCENTAGES

INTERVIEW NUMBER ______________

Date ________________ Interviewer____________________

Address of Interview ______________________________________

Starting Time __________________________ AM PM

Closing Time __________________________ AM PM

Elapsed Time __________________________ MINUTES

[I: READ]

Hello. I'm (________________________) from Eastern Michigan University in Ypsilanti. I'd like to talk with you for a little while and ask you a few questions about how you are doing and life here in Detroit. This is part of a project to learn more about older people who are having a hard time. We hope you can help. Everything you say will be confidential. I don't need to write down your name and there is no way for anyone to know what your answers are. If there is a question that you'd rather not answer, you don't have to. If you want to quit the interview at any time, that's alright too. All I am interested in is your best answers to the questions.

Will you help by answering a few questions?

YES...___

NO....___

[If No] I: Thank you for letting me ask for your help.

[If Yes] I: Thank you. Will you be comfortable here? [If No, find appropriate location near the site. If Yes, begin interview]

1. Are you a resident of Detroit?

		%
YES...[Skip to 3.]...	82	96.5
NO..................	3	3.5
REFUSED.............	0	
DON'T KNOW, CONFUSED.	0	

2. [For non-residents] Where do you live; in what city and state?

City.........._______________________

State.........._______________________

3. Where will you sleep tonight?

		%
Hotel/Motel Room	19	22.6
Shelter	20	23.8
Friend's or Relative's Place or Home	20	23.8
Some Other Place [specify]	25	29.8

____

4. How long have you [Residents] lived in Detroit?
[Non-Residents] been in Detroit?

24 Hours or Less	0	0.0
1 to 7 days	0	0.0
More than one week	1	1.2
More than a week but less than a month	0	0.0
1 to 6 months	4	4.7
More than 7 months but less than a year	3	3.5
1 to 5 years	5	5.9
More than 5 years	72	84.7

5. How long do you think you'll stay here?

Less than a week	3	3.6
1-4 weeks	2	2.4
1-6 months	4	4.8
6 months to a year	7	8.4
More than a year	60	72.3
Don't know	7	8.4

6. As of today, do you have a regular place that you consider to be your home?

Yes	39	45.9
No	45	52.9

7. [If Yes] Where is that place? _______________________

____

[If Yes to 7.] How long has it been since you were there?

		%
Less than a week	11	13.4
1 to 4 weeks	1	1.2
About a month	2	2.4
More than a month, less than a year	2	2.4
About a year	1	1.2
More than a year	9	11.6

[If No] How long has it been since you had a regular home?

Less than a week	2	2.4
1 to 4 weeks	3	3.7
About a month	4	4.9
More than a month, less than a year	14	17.1
About a year	6	7.3
More than a year	27	32.9

8. **Do you expect to have a place to live in the near future?**

Yes	35	42.7
No	18	22.0
Refused	1	1.2
Don't Know	27	32.9

9. **[If Yes] Where do you think that will be?**

[Exact words] ______________________________

____

[If No] Go to 10.

10. When you last lived in a regular place, did you live alone or with someone else?

		%
Alone...............	37	46.3
With Someone	43	53.8

11. [If Alone] When was the last time you lived with someone?

Year ....________________

[If With Someone] Who did you live with?

Spouse................	23	31.1
Children..............	6	8.1
Relative(s)...........	15	20.3
Friend(s).............	13	17.6
Unrelated Adult(s)....	7	9.5

12. Is this the first time you have been without a regular place to live?

Yes..................	43	53.1
No...................	36	44.4

13. [If Yes, go on to 15., If No] Were you without a regular place to live in:

Yes No

1987?.......	32	39.5	________
1986?.......	30	37.0	________
1985?.......	28	34.6	________
1984?.......	26	32.1	________
Other times?	20	24.7	

14. Do you usually sleep or rest during the day, or at night, or both day and night?

Day..................	3	3.8
Night................	46	59.0
Both Day & Night.....	29	37.2

15. Have you ever been thrown out of a place or refused admission to a place to sleep when you were homeless?

		%
Yes	24	28.6
No	48	57.1
Refused	4	4.8
Don't Remember	8	9.5

16. In the past month have you worked for pay?

Yes	11	12.9
No	73	85.9
Refused	1	1.2
Don't Know	0	0.0

17. [If Yes] What kind of work was that? [If No, go on to Question 19)

____

____

18. [If Yes to 16.] Did that job earn you enough money to meet your needs?

Yes	6	24.0
No	16	64.0
Refused	1	4.0
Don't Know	2	8.0

19. Are you interested in working for pay or getting a regular job?

Yes	52	62.7
No	26	31.3
Maybe, depends, etc.	5	6.0

20. Over the last month, have you received any money from any of the following?

	Yes	%	No	%
Welfare, Department of Social Services General Assistance	30	36.1	53	63.9
Social Security	30	35.7	54	64.3
A Retirement Pension		78.5	75	91.5
Your Relatives or Family	3	3.6	81	96.4
Friends	6	7.1	78	92.9
Unemployment Insurance	1	1.2	83	98.8
SSI (Supplemental Security Income Not including old age pension)	16	19.0	68	81.0
Disability Payments	6	7.2	77	92.8
Veteran's Administration Benefits	7	8.3	77	91.7
Selling your personal belongings	8	9.5	76	90.5
Gifts	5	6.0	79	94.0
Handouts from strangers	15	17.9	69	82.1
Collecting bottles & cans for refunds	37	44.0	47	56.0
Any Other Source of Money	10	12.2	72	87.8

21. Which of the following is closest to the amount of money you had last month?

		%
Less than $200	35	42.7
$200 - 299	17	20.7
$300 - 399	12	14.6
$400 - 499	8	9.8
$500 - 599	3	3.7
More than $600	7	8.5

22. During the last year, has [the amount from 21.] been about your average monthly income?

		%
Yes	74	90.2
No	8	9.8

23. [If Yes, go on to 24.] If No: What has been your average monthly income from all sources during the last year?

		%
Less than $200	4	22.1
$200 - 299	6	33.3
$300 - 399	3	16.7
$400 - 499	3	16.7
$500 - 599	1	5.6
More than $600	1	5.6

24. Over the last month have you received any of the following kinds of help?

	Yes		No	
		%		%
Medicaid	26	31.3	57	68
Food Stamps	20	24.1	63	75
Clothing	33	39.3	51	60
Free Meals	70	83.3	14	16
A Free Place to Sleep	38	45.2	46	54

25. Do you think you are taking advantage of all community services that might be available to you?

		%
Yes	21	25.0
No	40	47.6
Don't Know	22	26.2
Refused	1	1.2

26. In the last month was there any time when you didn't get anything, or barely anything, to eat for 2 days or more?

		%
Yes	36	42.9
No	46	54.8
Refused	0	0.0
Don't Know	2	2.4

27. Have you ever had any of the following experiences?

	Yes		No		D.K.	Ref.
		%		%		
Served in the Military.......	35	41.7	49	58.3	0.0	0.0
Been a Patient in a Drug or Alcohol Detoxification (Detox) Program.........	25	30.5	55	67.1	11.2	11.2
Served Time in a State or Federal Prison...............	19	22.6	63	75.0	0.0	22.4
Served Time in a City or County Jail..................	39	46.4	44	52.4	0.0	11.2
Been a Patient in a Hospital.	65	77.4	18	21.4	0.0	11.2
Been Placed on Probation by a Court....................	31	37.3	51	61.4	0.0	11.2
Been Admitted to a Mental Hospital.....................	27	32.5	56	67.5	0.0	0.0

28. What would you say has been the worst thing that has happened to you in the last few years? What would you say has happened to you that should never happen to anyone?

[Exact words] ____________________

29. Have you ever been unable to get to a doctor or a medical clinic because you couldn't get transportation?

		%
Yes..............	35	41.7
No...............	49	58.3

30. Have you ever been unable to get or to keep a job because you couldn't get transportation?

		%
Yes.............	23	27.7
No..............	60	72.3

31. **Some people have many relatives and friends while others have only a few. How about you?**

[For each Yes in A, Ask B and C]

		A			B			C		
		Do you have:			**Do you visit talk to or write to him/her/them at least once every two or months?**			**Does/Do he/she/they live in Detroit or a Detroit suburb?**		
		Yes 1	No 2	DK 3	Yes 1	No 2	DK 3	Yes 1	No 2	DK 3
One or both parents living?	14	17.1%			10			6		
One or more brothers or sisters living?	60	71.4%			24			21		
Other relatives like grandchildren aunts, uncles, cousins, nieces or nephews?										
Adult children?										
Adopted or foster children?										
One or more friends you can count on?										

32. [Is the respondent in touch with parents, siblings, or other relatives living in the Detroit area?

		%
Yes...[Ask questions 33. and 34.]	27	35.5
No...[Skip to question 35.]	49	64.5

33. You mentioned that you have (parents/brothers or sisters/other relatives) here in the Detroit area. Assuming that they would want to and have the room, would you be opposed to or in favor of going to live with them?

		%
Opposed	18	54.4
In favor	10	30.3
Refused	1	3.0
Don't Know	4	12.1

34. As far as you know, would your (parents/brothers or sisters/other relatives) here in the Detroit area be opposed to or in favor of your moving in with them?

		%
Opposed	14	41.2
In favor	14	41.2
Refused	1	2.9
Don't Know	5	14.7

35. Would you say your health, in general, now is excellent, good, fair or poor?

		%
Excellent	5	6.0
Good	32	38.1
Fair	29	34.5
Poor	18	21.4

36. **During the past year (that is, since (one year ago), have you been a patient in a hospital, a nursing home or a treatment center of some kind? [Do not include mental hospitals]**

		%
Yes	41	48.8
No	43	51.2
Refused	0	
Don't Know	0	

37. **During the past year (that is, since (one year ago), have you been a patient in a mental hospital or community mental health center?**

		%
Yes	8	9.5
No	76	90.5
Refused	0	
Don't Know	0	

38. **Have you ever been a patient in a mental hospital in Michigan or some other state?**

		%
Yes	22	26.2
No	61	72.6
Refused	0	
Don't Know	1	1.2

39. **When was the last time you saw a physician or a nurse in a medical office?**

Did respondent remember? 77 92.8 6 7.2

Exact remembered date: ______________ Month ______________ Year

40. **Over the last year, since (one year ago) was there any time when you needed or thought you needed medical care but could not get it?**

Within 3 mo.	38	48.7	Yes	26	31.0
3-6 mo.	12	15.4	No	55	65.5
6 mo - 1 yr.	6	7.7	Refused	0	
1 year plus	22	28.2	Don't Know	3	33.6

[IF YES, WHY?]______________________________________

41. **Now I am going to ask some questions about how you felt over the LAST WEEK. Tell me whether you never felt that way last week, felt that way some of the time, or felt that way most of the time last week.**

	NEVER		SOME OF THE TIME		MOST OF THE TIME		REFUSED	DON'T KNOW	
	1	%	2	%	3	%	4	5	%
Was your appetite so poor that you did not feel like eating?	51	60.7	30	35.7	3	3.6	0	0	
Did you feel so tired & worn out that you could not enjoy anything?	26	31.0	45	53.6	13	15.5	0	0	
Did you feel depressed?	31	36.9	41	48.8	81	9.5	0	4	4.8
Did you feel unhappy about the way your life is going?	20	23.8	34	40.5	28	33.3	0	2	2.4
Did you feel discouraged about the future?	28	33.7	30	36.1	21	25.3	0	4	4.8
Did you feel lonely?	37	44.0	29	34.5	18	21.4	0	0	

42. **Over the last week, that is seven days, how many times did you sleep or rest...**

	ONCE	TWICE	THREE TIMES	MORE THAN THREE TIMES	
	1	2	3	4	
in a shelter?				25	30.1
in a rented room?				28	33.3
on the streets or in a park?				12	14.5
in someone else's home?				11	13.3
in an empty building?				4	4.8
in a library, bus station, all night movie, airport, or some other public place?				1	1.2

43. **Now I would like to ask you about some activities that we usually need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, if you need some help to do them, or if you cannot do them at all.**

[Read all answer choices to each question]

Can you use the telephone?

		%
Without any help at all........	76	90.5
With some help.................	5	6.0
Cannot use the telephone without help..................	3	3.6

Can you walk twenty feet?

Without any help at all........	79	94.0
With some help.................	3	3.6
Cannot walk twenty feet at all	1	1.2

Can you take a bath or shower?

Without any help at all........	82	97.6
With some help.................	1	1.2
Cannot take a bath or shower without help..................	1	1.2

Can you take your own medicines?

Without any help at all........	81	97.6
With some help.................	2	2.4
Cannot take medicines without help..................	0	0.0

Can you dress yourself and take care of your possessions?

Without any help at all........	82	97.6
With some help.................	2	2.4
Cannot dress or take care of possessions..................	0	0.0

44. When you are out on the street or in the community are you afraid of being hurt, robbed, or abused by someone?

		%
All the time	16	19.0
Most of the time	15	17.9
Sometimes	18	21.4
Not very often	21	25.0
Never, or hardly ever	14	16.7

45. When you buy something do you usually decide to purchase...

[Read each option; check only one]

only after careful consideration?	40	47.6
on the spur of the moment, because you have the money and aren't sure if you'll get another chance?	23	27.4
whenever you feel like it?	20	23.8
don't know	1	1.2

46. Do you feel like you know how to achieve whatever you want to achieve?

All the time	21	25.0
Most of the time	31	36.8
Sometimes	15	17.9
Not very often	12	14.3
Never, or hardly ever	3	3.6
Don't know	2	2.4

47. When you have time on your hands, how do you pass the time?

[EXACT WORDS ______________________________

____

____

48. During the last year have you been a victim of crime?

		%
Yes............	43	51.2
No.............	41	40.8

49. If "Yes" which of the following crimes have been committed against you?

Have you been:			
	Robbed....................	36	55.5
	Beaten or physically hurt.	22	32.4
	Raped.....................	7	10.4
	Deprived of your legal rights....................	10	14.9
	Other.....................		

Explain (exact words)

50. Are you afraid of being a victim of crime again?

		%
Yes............	41	58.6
No.............	28	40.0
Don't know.....		

51. What is your birth date? When were you born?

MONTH DAY YEAR

[CALCULATE RESPONDENT'S AGE]

AGE		%	AGE		%
54-59	3	3.5	70-74	12	14.1
60-64	39	45.9	75-79	5	5.9
65-69	22	25.9	80+	2	2.4

52. What is your present marital status? [Read each alternative]

		%
MARRIED AND NEITHER DIVORCED NOR SEPARATED	6	7.2
DIVORCED OR SEPARATED	31	37.3
WIDOWED	16	19.3
SINGLE AND NEVER MARRIED	26	31.3
ABANDONED	3	3.6
REFUSED	1	1.2
DON'T KNOW	-	-

53. How many years of schooling did you complete?

0 - 7 DID NOT FINISH ELEMENTARY SCHOOL	14	16.7
8 - 11 DID NOT GRADUATE FROM HIGH SCHOOL	35	41.7
12 HIGH SCHOOL OR G.E.D	18	21.4
SOME COLLEGE OR POST-HIGH SCHOOL	13	15.5
POST HIGH SCHOOL TRADE SCHOOL	1	1.2
COLLEGE GRADUATE	3	3.6
GRADUATE DEGREE OR PROFESSIONAL DEGREE	-	-
REFUSED	-	-
DON'T KNOW	-	-

TERMINATION PARAGRAPH [READ TO EACH RESPONDENT] 17

THOSE ARE ALL THE QUESTIONS I HAVE FOR YOU. THANK YOU VERY MUCH FOR YOUR TIME & YOUR HELP! YOUR HELP HAS MADE MY JOB MUCH EASIER! EVERYTHING YOU HAVE TOLD ME WILL BE KEPT CONFIDENTIAL. NOBODY CAN IDENTIFY YOU FROM THIS INTERVIEW AND YOUR NAME WILL NEVER BE USED; IN FACT, I HAVE NOT WRITTEN YOUR NAME ON THIS INTERVIEW FORM. THANK YOU AGAIN!

INTERVIEWER'S OBSERVATIONS AND COMMENTS

RESPONDENT'S GENDER:	MALE.......	66	79.5
	FEMALE.....	17	20.5
RACE:	WHITE......	33	39.8
	BLACK......	47	56.6
	OTHER......	3	3.6
	DON'T KNOW.......	-	

DID RESPONDENT APPEAR TO BE ANY (OR ALL) OF THE FOLLOWING?

	YES	%	NO	%
DRUNK.............	4	4.8	79	95.2
UNDER INFLUENCE OF DRUGS..........	2	2.4	81	97.6
SERIOUSLY ILL.....	7	8.4	76	91.6
CONFUSED..........	22	26.5	61	73.5
INCONTINENT.......	3	3.6	80	96.4
DIRTY/UNKEMPT.....	25	30.1		
POORLY DRESSED....	38	45.8		
CARRYING PACKAGES..........	15	18.1		
LUCID AND ALERT...	48	57.8		
NEAT AND CLEAN....	35	42.2		
FEARFUL OR AFRAID............	11	13.3		

54. Have you ever had any of the following problems?
[If Yes, ask immediately: How much does it interfere with your daily activities? Check appropriate response: NAA = NOT AT ALL, AL = A LITTLE, GD = A GREAT DEAL]

	RESPONSE				**DEGREE OF EFFECT**		
	N		**Y**		**NAA**	**AL**	**GD**
ARTHRITIS/RHEUMATISM	40	47.6	44	52.4	5	27	14
GLAUCOMA	70	83.3	14	16.7	2	7	3
ASTHMA	73	86.9	11	13.1	4	7	1
EMPHYSEMA/CHRONIC BRONCHITIS	56	66.7	28	33.3	7	17	4
TUBERCULOSIS	73	88.0	10	12.0	5	2	3
HIGH BLOOD PRESSURE	47	56.0	37	44.0	8	17	10
HEART TROUBLE	63	75.0	21	25.0	7	9	4
CIRCULATORY TROUBLE IN ARMS OR LEGS	54	64.3	30	35.7	4	19	7
DIABETES	78	92.9	6	7.1	2	2	2
ULCERS (STOMACH, DIGESTIVE)	66	78.6	18	21.4	2	8	7
OTHER STOMACH AILMENTS	66	78.6	18	21.4	1	10	7
LIVER DISEASE (YELLOW SKIN)	77	91.7	7	8.3	2	2	3
KIDNEY DISEASE	76	90.5	8	9.5	1	3	4
OTHER URINARY TRACT DISORDER	73	86.9	11	13.1	3	5	2
CANCER (ANY KIND), SPECIFY ________________________	80	95.2	4	4.8	2	2	0
ANEMIA	77	91.7	7	8.3	1	5	0
STROKE, EFFECTS OF STROKE	73	86.9	11	13.1	3	5	3
PNEUMONIA	57	67.9	27	32.1	14	8	3
IRREGULAR HEART BEAT	61	72.6	23	27.4	9	9	3
DENTAL PROBLEMS OR DENTURES	29	34.5	55	65.5	12	16	21

55. **Have you ever had memory problems? By that I mean trouble remembering things that you think you ought to remember?**

		%
YES..................	38	45.2
NO..................	43	51.2
REFUSE...............	0	0.0
DON'T KNOW...........	3	3.6

56. **Have you ever had sleep problems? By that I mean trouble getting to sleep, or sleeping when most people are awake, or not being able to be asleep long enough to be rested?**

YES..................	42	51.2
NO..................	40	48.8
REFUSE...............	0	0.0
DON'T KNOW...........	0	0.0

57. **Do you use any of the following devises or equipment all or most of the time?**

	N	Y		N	Y		
HEARING AIDS	4	4.8	EYE GLASSES/CONTACTS..	15	18.1	68	81.9
DENTURE PLATES...	16	19.3	WALKING CANE..........	69	83.1	14	16.9
WALKER...........	4	4.8	WHEEL CHAIR...........			2	2.4
LEG BRACE........	0		BACK BRACE.............			2	2.4
ARTIFICIAL LIMB..	0		ANKLE BRACE............			3	3.6
BLADDER CATHETER.	0		COLOSTOMY..............			3	3.6
PACEMAKER........	0		OTHER DEVICE...........			1	1.2

SPECIFY________________________

58. **Do you need any supportive or prosthetic devices that you do not have at this time?**

NO.................	59	71.1
YES...[SPECIFY]....	24	28.9

glasses

59. [Stress Index]
What part of your daily activities gives you the most problems? [Exact words]

60. **How do you handle this (these) problem(s)?**

61. [Hassles Index]
The following questions deal with things we all experience. Over the last month, how much of a problem have these things been for you? For example, if in the first experience you have not been concerned or affected by news events, then you would indicate that it has not been a hassle. If you have been affected by certain news events then you would indicate how much of a hassle it has been.

CONCERNS ABOUT NEWS EVENTS: (Do you worry about things that you hear about on TV News or read about in the newspapers?)

	Not a Hassle 1		Somewhat Serious 2		Moderately Serious 3		Extremely Serious 4	
a.	43	51.8%	22	26.5%	9	10.8%	9	10.8%

CONCERNS ABOUT CRIME: (Do you worry about the amount of crime in this area?)

	Not a Hassle 1		Somewhat Serious 2		Moderately Serious 3		Extremely Serious 4	
b.	23	27.7%	16	19.3%	18	21.7%	26	31.3%

CONCERNS ABOUT POLLUTION: (Do you worry about the air you breathe, the water you drink or about toxic waste?)

	Not a Hassle 1		Somewhat Serious 2		Moderately Serious 3		Extremely Serious 4	
c.	48	57.8%	13	15.7%	8	9.6%	14	16.9%